Basic				
Deductible: $0 Annual Plan Maximum: $1,000 Out of Network Allowance: Not Applicable (In Network Only)				
ADA Code	Procedure Description	In Network Coinsurance	Out of Network Coinsurance	Frequency Limit
Diagnostic				
D0120	Periodic Oral Evaluation	0%	Not Covered	2 per calendar year
D0140	Limited Oral Evaluation - Problem Focused	0%	0%	2 per calendar year
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0%	Not Covered	2 per calendar year
D0160	Detailed and extensive oral evaluation - problem-focused, by report	0%	Not Covered	2 per calendar year
D0180	Comprehensive periodontal evaluation - new or established patient	0%	Not Covered	2 per calendar year
D0190	Screening of a patient	0%	Not Covered	Unlimited
D0210	Intraoral - Complete Series Of Radiographic Images	0%	Not Covered	1 per consecutive 36 months
D0270	Bitewing - Single Radiographic Image	0%	Not Covered	8 per calendar year
D0272	Bitewing - Two Radiographic Images	0%	Not Covered	4 per calendar year
D0273	Bitewing - Three Radiographic Images	0%	Not Covered	2 per calendar year
D0274	Bitewings - Four Radiographic Images	0%	Not Covered	2 per calendar year
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0%	Not Covered	1 per consecutive 36 months
D0330	Panoramic Radiographic Image	0%	Not Covered	1 per consecutive 36 months
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	0%	Not Covered	1 per consecutive 36 months
D0373	Intraoral tomosynthesis - bitewing radiographic image	0%	Not Covered	2 per calendar year
D0387	Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only	0%	Not Covered	1 per consecutive 36 months
D0388	Intraoral tomosynthesis - bitewing radiographic image - image capture only	0%	Not Covered	2 per calendar year
D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions	0%	Not Covered	1 per consecutive 36 months
D0701	panoramic radiographic image - image capture only	0%	Not Covered	1 per consecutive 36 months
D0702	2-D cephalometric radiographic image - image capture only	0%	Not Covered	1 per consecutive 36 months
D0708	intraoral - bitewing radiographic image - image capture only	0%	Not Covered	8 per calendar year
D0709	intraoral - complete series of radiographic images - image capture only	0%	Not Covered	1 per consecutive 36 months
Preventive				
D1110	Prophylaxis - adult	0%	Not Covered	2 per calendar year

D1206	Topical application of fluoride varnish	0%	Not Covered	2 per calendar year
D1208	Topical application of fluoride - excluding varnish	0%	Not Covered	2 per calendar year
Restorative				
D2140	amalgam - one surface, primary or permanent	50%	Not Covered	Unlimited
D2150	amalgam - two surfaces, primary or permanent	50%	Not Covered	Unlimited
D2160	amalgam - three surfaces, primary or permanent	50%	Not Covered	Unlimited
D2161	amalgam - four or more surfaces, primary or permanent	50%	Not Covered	Unlimited
D2330	resin-based composite - one surface, anterior	50%	Not Covered	Unlimited
D2331	resin-based composite - two surfaces, anterior	50%	Not Covered	Unlimited
D2332	resin-based composite - three surfaces, anterior	50%	Not Covered	Unlimited
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	50%	Not Covered	Unlimited
D2390	resin-based composite crown, anterior	50%	Not Covered	1 per consecutive 60 months
D2391	resin-based composite - one surface, posterior	50%	Not Covered	Unlimited
D2392	resin-based composite - two surfaces, posterior	50%	Not Covered	Unlimited
D2393	resin-based composite - three surfaces, posterior	50%	Not Covered	Unlimited
D2394	resin-based composite - four or more surfaces, posterior	50%	Not Covered	Unlimited
D2910	recement or re-bond inlay, onlay, veneer or partial coverage restoration	50%	Not Covered	1 per consecutive 12 months
D2920	recement or re-bond crown	50%	Not Covered	1 per consecutive 12 months
D2940	placement of interim direct restoration	50%	Not Covered	Unlimited
D2951	pin retention - per tooth, in addition to restoration	50%	Not Covered	1 per consecutive 60 months
D2954	prefabricated post and core in addition to crown	50%	Not Covered	1 per consecutive 60 months
D2980	crown repair necessitated by restorative material failure	50%	Not Covered	1 per consecutive 6 months
D2989	excavation of a tooth resulting in the determination of non-restorability	50%	Not Covered	Unlimited
Oral Surgery				
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	50%	Not Covered	1 per tooth per lifetime
D7210	extraction, erupted tooth req removal of bone,sectioning of tooth and including elevation of mucoperiosteal flap	50%	Not Covered	1 per tooth per lifetime

Adjunctive General Services				
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	0%	0%	Unlimited
D9112	pre-visit patient screening	0%	0%	2 per calendar year
D9995	teledentistry - synchronous; real-time encounter	0%	0%	2 per calendar year
D9996	teledentistry-asynchronous; information stored and forwarded to dentist for subsequent review	0%	0%	2 per calendar year

DENTAL LIMITATIONS & EXCLUSIONS

LIMITATIONS

1. Oral Evaluations (D0120-D0160, D0180) are limited to 2 times per 12 consecutive months.
2. Intraoral-Complete Series, Vertical Bitewings and Panorex Radiographs (D0210, D0277 and D0330) are limited to 1 time per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.
3. Bitewing Radiographs (D0270, D0272, D0273 and D0274) are limited to 2 series of films per plan year.
4. Dental Prophylaxis (D1110) is limited to 2 times per 12 consecutive months.
5. Fluoride Treatment (D1206 and D1208) is limited to Covered Persons under the age of 16 yearsand limited to 2 times per consecutive 12 months.
6. Palliative Treatment (D9110) is covered as a separate benefit only if no other service, other than radiographs and exam, were done on the same tooth during the visit.

EXCLUSIONS

General Exclusions (The following are not covered.)

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. Cosmetic procedures are those procedures that improve physical appearance.
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures that began prior to the Covered Person becoming enrolled under the Policy.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

11.	Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12.	Foreign services are not covered unless required as an emergency.
13.	Procedures related to the reconstruction of a patient's correct Vertical Dimension of Occlusion (VDO).
14.	Placement of dental implants, implant-supported abutments and prostheses (D6010; D6012-D3019; D6021-D6052 D6055-D6077; D6080-D6199).
15.	Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital malformations of hard or soft tissue, including excision (D7413-D7415, D7440-D7441, D7490).
16.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue (D7610 – D7780).
17.	Services related to the temporomandibular joint (TMJ), either bilateral or unilateral (D7810 – D7899). Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery (D7920-D7949), jaw alignment, or treatment for the temporomandibular joint.
18.	Acupuncture; acupressure and other forms of alternative treatment whether or not used as anesthesia.
19.	Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
20.	In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.
21.	Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.