Dental Silver

Deductible: $0
Annual Plan Maximum: $1,500
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
D0220	Intraoral - Periapical First Radiographic Image	0%	Not Covered	8 per calendar year
D0230	Intraoral - Periapical Each Additional Radiographic Image	0%	Not Covered	8 per calendar year
D0240	Intraoral - Occlusal Radiographic Image	0%	Not Covered	2 per consecutive 6 months
D0250	Extraoral - 2D Projection Radiographic Image Created Using A Stationary Radiation Source And Detector	0%	Not Covered	2 per calendar year
D0270	Bitewing - Single Radiographic Image	0%	Not Covered	8 per calendar year
D0272	Bitewings - Two Radiographic Images	0%	Not Covered	4 per calendar year
D0273	Bitewings - 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
D0374	Intraoral tomosynthesis - periapical radiographic image	0%	Not Covered	8 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
D0389	Intraoral tomosynthesis - periapical radiographic image - image capture only	0%	Not Covered	8 per calendar year

D0701	D0701-panoramic radiographic image – image capture only	0%	Not Covered	1 per consecutive 36 months
D0702	D0702-2-D cephalometric radiographic image – image capture only	0%	Not Covered	1 per consecutive 36 months
D0706	D0706-intraoral – occlusal radiographic image – image capture only	0%	Not Covered	2 per consecutive 6 months
D0707	D0707-intraoral – periapical radiographic image – image capture only	0%	Not Covered	8 per calendar year
D0708	D0708-intraoral – bitewing radiographic image – image capture only	0%	Not Covered	8 per calendar year
D0709	D0709-intraoral – complete series of radiographic images – image capture only	0%	Not Covered	1 per consecutive 36 months
D0999	Unspecified diagnostic procedure, by report	0%	Not Covered	Unlimited
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
D1510	Space Maintainer - Fixed - Unilateral	0%	Not Covered	1 per consecutive 60 months
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	0%	Not Covered	1 per consecutive 60 months
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	0%	Not Covered	1 per consecutive 60 months
D1520	Space Maintainer - Removable - Unilateral	0%	Not Covered	1 per consecutive 60 months
D1526	Space Maintainer – Removable – Bilateral, Maxillary	0%	Not Covered	1 per consecutive 60 months
D1527	Space Maintainer – Removable – Bilateral, Mandibular	0%	Not Covered	1 per consecutive 60 months
D1551	re-cement or re-bond bilateral space maintainer - maxillary	0%	Not Covered	1 per consecutive 6 months
D1552	re-cement or re-bond bilateral space maintainer - mandibular	0%	Not Covered	1 per consecutive 6 months
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	0%	Not Covered	1 per consecutive 6 months
D1556	removal of fixed unilateral space maintainer - per quadrant	0%	Not Covered	Unlimited
D1557	removal of fixed bilateral space maintainer - maxillary	0%	Not Covered	Unlimited
D1558	removal of fixed bilateral space maintainer - mandibular	0%	Not Covered	Unlimited
D1575	Distal Shoe Space Maintainer - Fixed Unilateral	0%	Not Covered	1 per consecutive 60 months
D1999	Unspecified preventive procedure, by report	0%	Not Covered	Unlimited

Restorative				
D2140	Amalgam - One Surface, Primary Or Permanent	0%	Not Covered	Unlimited
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0%	Not Covered	Unlimited
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0%	Not Covered	Unlimited
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0%	Not Covered	Unlimited
D2330	Resin-Based Composite - One Surface, Anterior	0%	Not Covered	Unlimited
D2331	Resin-Based Composite - Two Surfaces, Anterior	0%	Not Covered	Unlimited
D2332	Resin-Based Composite - Three Surfaces, Anterior	0%	Not Covered	Unlimited
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	0%	Not Covered	Unlimited
D2390	Resin-Based Composite Crown, Anterior	50%	Not Covered	1 per consecutive 60 months
D2391	Resin-Based Composite - One Surface, Posterior	0%	Not Covered	Unlimited
D2392	Resin-Based Composite - Two Surfaces, Posterior	0%	Not Covered	Unlimited
D2393	Resin-Based Composite - Three Surfaces, Posterior	0%	Not Covered	Unlimited
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0%	Not Covered	Unlimited
D2910	Recement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	50%	Not Covered	1 per consecutive 12 months
D2915	Recement Or Re-Bond Cast Indirectly Fabricated Or Prefabricated Post And Core	50%	Not Covered	1 per consecutive 12 months
D2920	Recement Or Re-Bond Crown	50%	Not Covered	1 per consecutive 12 months
D2921	Reattachment Of Tooth Fragment, Incisal Edge Or Cusp	50%	Not Covered	1 per consecutive 6 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
D2980	Crown Repair Necessitated By Restorative Material Failure	50%	Not Covered	1 per consecutive 6 months
D2981	Inlay Repair Necessitated By Restorative Material Failure	50%	Not Covered	1 per consecutive 6 months
D2982	Onlay Repair Necessitated By Restorative Material Failure	50%	Not Covered	1 per consecutive 6 months
D2983	Veneer 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
D2999	Unspecified restorative procedure, by report	50%	Not Covered	Unlimited
Endodontics				
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime
D3221	Pulpal Debridement, Primary And Permanent Teeth	50%	50%	1 per tooth per lifetime
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth With Incomplete Root Development	50%	Not Covered	1 per tooth per lifetime
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth	50%	Not Covered	1 per tooth per lifetime
D3333	Internal Tooth Repair Of Performation Defects	50%	Not Covered	1 per tooth per lifetime
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	50%	Not Covered	1 per tooth per lifetime
D3347	Retreatment Of Previous Root Canal Therapy - Bicuspid	50%	Not Covered	1 per tooth per lifetime
D3348	Retreatment Of Previous Root Canal Therapy - Molar	50%	Not Covered	1 per tooth per lifetime
D3351	Apexification/Recalcification-Initial Visit (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc	50%	Not Covered	1 per tooth per lifetime
D3352	Apexification/Recalcification/Pulpal Regeneration - Interim Medication Replacement	50%	Not Covered	1 per tooth per lifetime
D3353	Apexification/Recalcification - Final Visit (Includes Completed Root	50%	Not Covered	1 per tooth per lifetime
D3410	Apicoectomy - Anterior	50%	Not Covered	1 per tooth per lifetime
D3421	Apicoectomy - Premolar (First Root)	50%	Not Covered	1 per tooth per lifetime

D3425	Apicoectomy - Molar (First Root)	50%	Not Covered	1 per tooth per lifetime
D3426	Apicoectomy (Each Additional Root)	50%	Not Covered	2 per tooth per lifetime
D3430	Retrograde Filling - Per Root	50%	Not Covered	1 per tooth per lifetime
D3450	Root Amputation - Per Root	50%	Not Covered	1 per tooth per lifetime
D3471	D3471-surgical repair of root resorption - anterior	50%	Not Covered	1 per tooth per lifetime
D3472	D3472-surgical repair of root resorption – premolar	50%	Not Covered	1 per tooth per lifetime
D3473	D3473-surgical repair of root resorption – molar	50%	Not Covered	1 per tooth per lifetime
D3501	D3501-surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	50%	Not Covered	1 per tooth per lifetime
D3502	D3502-surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	50%	Not Covered	1 per tooth per lifetime
D3503	D3503-surgical exposure of root surface without apicoectomy or repair of root resorption – molar	50%	Not Covered	1 per tooth per lifetime
D3911	intraoffice barrier	50%	Not Covered	Unlimited
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	50%	Not Covered	1 per tooth per lifetime
D3999	Unspecified endodontic procedure, by report	50%	Not Covered	Unlimited
Periodontics				
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months
D4240	Gingival Flap Procedure, Including Root Planning - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months
D4241	Gingival Flap Procedure - Including Root Planing -One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months
D4245	Apically Positioned Flap	50%	Not Covered	1 per quadrant per consecutive 36 months
D4249	Clinical Crown Lengthening - Hard Tissue	50%	Not Covered	1 per consecutive 36 months

D4260	Osseous Surgery (Including Flap Entry And Closure) - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months
D4261	Osseous Surgery (Including Flap Entry And Closure) - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	50%	Not Covered	1 per consecutive 36 months
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Additional Site In Quadrant	50%	Not Covered	1 per consecutive 36 months
D4265	biologic materials to aid in soft and osseous tissue regeneration, per site	50%	Not Covered	1 per consecutive 36 months
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	50%	Not Covered	1 per consecutive 36 months
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	50%	Not Covered	1 per consecutive 36 months
D4268	Surgical Revision Procedure, Per Tooth	50%	Not Covered	1 per consecutive 36 months
D4270	Pedicle Soft Tissue Graft Procedure	50%	Not Covered	1 per consecutive 36 months
D4273	Autogenous Connective Tissue Graft Procedure, Per First Tooth, Implant Or Endentulous Tooth Position In Graft	50%	Not Covered	1 per consecutive 36 months
D4274	Mesial/Distal Wedge Procedure Single Tooth(When Not Performed In Conjunction With Surgical Procedures In The Same Area	50%	Not Covered	1 per consecutive 36 months
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site And Donor Material) First Tooth Implant	50%	Not Covered	1 per consecutive 36 months
D4276	Combined connective tissue and pedicle graft, per tooth	50%	Not Covered	1 per consecutive 36 months
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites)First Tooth, Implant, Or Edentulous Tooth	50%	Not Covered	1 per consecutive 36 months
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous position	50%	Not Covered	1 per consecutive 36 months
D4283	Autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	Not Covered	1 per consecutive 36 months
D4285	Non-autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	Not Covered	1 per consecutive 36 months

D4286	Removal of non-resorbable barrier	50%	Not Covered	Unlimited
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 24 months
D4342	Periodontal Scaling And Root Planing - One - Three Teeth, Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 24 months
D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation	50%	Not Covered	2 per consecutive 12 months
D4355	Full Mouth Debridement To Enable A Comprehensive Oral Evaluation And Diagnosis On A Subsequent Visit	50%	Not Covered	1 per consecutive 36 months
D4910	Periodontal Maintenance	50%	Not Covered	2 per calendar year
D4999	Unspecified periodontal procedure, by report	50%	Not Covered	Unlimited
Oral & Maxillofacial Surgery				
D7111	Extraction, Coronal Remnants - Primary Tooth	50%	Not Covered	1 per tooth per lifetime
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
D7220	Removal Of Impacted Tooth - Soft Tissue	50%	Not Covered	1 per tooth per lifetime
D7230	Removal Of Impacted Tooth - Partially Bony	50%	Not Covered	1 per tooth per lifetime
D7240	Removal Of Impacted Tooth - Completely Bony	50%	Not Covered	1 per tooth per lifetime
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical	50%	Not Covered	1 per tooth per lifetime
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	50%	Not Covered	1 per tooth per lifetime
D7251	Coronectomy – intentional partial tooth removal	50%	Not Covered	Unlimited
D7270	Tooth Reimplantation And/Or Stabilization Of Accidentally Evulsed Or Displaced Tooth	50%	Not Covered	1 per site per lifetime
D7280	Exposure Of An Unerupted Tooth	50%	Not Covered	1 per tooth per lifetime
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption	50%	Not Covered	1 per tooth per lifetime
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	50%	Not Covered	1 per tooth per lifetime
D7286	Incisional Biopsy Of Oral Tissue - Soft (All Others)	50%	Not Covered	1 biopsy per site per visit
D7290	Surgical repositioning of teeth	50%	Not Covered	Unlimited

D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report	50%	Not Covered	1 per tooth per lifetime
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7311	Alveoplasty In Conjunction With Extraction - One To Three Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7321	Alveoplasty Not In Conjunction With Extraction - One To Three Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	50%	Not Covered	1 per site per visit
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	50%	Not Covered	1 per site per visit
D7910	Suture of recent small wounds up to 5 cm	50%	Not Covered	Unlimited
D7956	Guided tissue regeneration, edentulous area - resorbable barrier, per site	50%	Not Covered	1 per consecutive 36 months
D7957	Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	50%	Not Covered	1 per consecutive 36 months
D7970	Excision Of Hyperplastic Tissue - Per Arch	50%	Not Covered	1 per site per consecutive 36 months
D7971	Excision Of Pericoronal Gingiva	50%	Not Covered	1 per site per consecutive 36 months
D7999	Unspecified oral surgery procedure, by report	50%	Not Covered	Unlimited
Adjunctive General Services				
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	0%	0%	Unlimited
D9912	pre-visit patient screening	0%	0%	2 per calendar year
D9943	Occlusal Adjustment	50%	Not Covered	1 per consecutive 6 months
D9948	adjustment of custom sleep apnea appliance	0%	Not Covered	1 per consecutive 6 months
D9955	oral appliance therapy (OAT) titration visit	0%	Not Covered	1 per consecutive 6 months
D9956	administration of home sleep apnea test	0%	Not Covered	1 per consecutive 6 months
D9957	screening for sleep related breathing disorders	0%	Not Covered	1 per consecutive 6 months

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. Intraoral – Periapical radiographs (D0220, D0230) are limited to a total of 8 films per plan year. Intraoral – Occlusal radiograph (D0240) is limited to2 per consecutive 6 months.
4. Extra-oral Radiographs (D0250) are limited to 2 films per plan year.
5. Bitewing Radiographs (D0270, D0272, D0273 and D0274) are limited to 2 series of films per plan year.
6. Dental Prophylaxis (D1110) is limited to 2 times per 12 consecutive months. Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (D4346) is limited to 2 times per 12 months.
7. Fluoride Treatment (D1206 and D1208) is limited to Covered Persons under the age of 16 years and limited to 2 times per consecutive 12 months.
8. Space Maintainers (D1510, D1516-D1517, D1520, D1526-D1527 and D1575) are limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
9. Re-cement or re-bond of Space Maintainers (D1550) are limited to 1 per consecutive 6 months after initial insertion.
10. Removal of Fixed Space Maintainer (D1555) does not have a frequency limit.
11. Multiple Restorations on 1 surface (D2140, D2330 and D2391) will be treated as a single filling.
12. Recement Inlays/Onlays (D2910), Crowns (D2920) and Post and Core (D2915) are limited to those performed more than 12 months after the initial insertion. Recements of inlays, onlays, post and cores and crowns are limited to 1 time per consecutive 12 months. Recements of bridges are limited to 1 time per consecutive 6 months.
13. Crowns (D2390) are limited to 1 per consecutive 60 months. Covered only when a filling cannot restore the tooth; not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.
14. Protective Restorations (D2940) are covered as a separate benefit only if no other service other than X-rays and exam, were done on the same tooth during the visit.
15. Pin Retention (D2951) is not covered in addition to Cast Restoration. Cast Restoration is defined as inlays and onlays. Limited to 1 time per consecutive 60 months.
16. Therapeutic Pulpotomy (D3220) is limited to 1 time per primary or secondary tooth per lifetime. Pulpal Therapy/Resorbable Filling (D3230 and D3240) is limited to 1 time per tooth per lifetime; covered for anterior or posterior teeth only.
17. Pulpal Debridement and Partial Pulpotomy for Apexogenesis (D3221 and D3222) are limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.
18. Root Canal Therapy (D3310 - D3333) is limited to 1 per tooth per lifetime. The dentist who performed the original root canal should not be reimbursed for the retreatment (D3346, D3347, D3348) for the first 12 months. Retreatment of Root Canals is limited to 1 time per lifetime.

19. Apexification (D3351, D3352, D3353), Apicoectomy (D3410, D3421, D3425), Retrograde filling (D3430), Root Resection/Amputation (D3450) are limited to 1 time per tooth per lifetime. Apicoectomy – each additional root (D3426) and periradicular surgery without apicoectomy (D3427) is limited to 2 times per tooth per lifetime.
20. Hemisection (D3920) is limited to 1 time per tooth per lifetime.
21. Crown Lengthening (D4249), Gingivectomy/Gingivoplasty (D4210, D4211), Gingival Flap Procedure (D4240, D4241, D4245), Osseous Graft (D4263, D4264, D4265), Osseous Surgery (D4260, D4261), Guided Tissue Regeneration (D4266, D4267), Soft Tissue Surgery (D4270, D4273, D4274, D4275, D4276, D4277; D4283, D4285) are limited to 1 per quadrant or site per consecutive 36 months.
22. Surgical Revision Procedure (D4268) is limited to 1 per consecutive 36 months
23. Scaling and Root Planing (D4341 and D4342) are limited to 1 time per quadrant per consecutive 24 months.
24. Full Mouth Debridement (D4355) is limited to 1 time per consecutive 36 months.
25. Periodontal Maintenance (D4910) is limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement (D4355).
26. Repairs and Adjustments to Crowns/Inlay/Onlay (D2980-D2982) are limited to those done more than 12 months after the initial insertion and limited to 1 per consecutive 6 months. Reattachment of tooth fragment, incisal edge or cusp (D2921) is limited to 1 per consecutive 6 months.
27. Simple Extractions (D7111, D7140), Extraction of Erupted Tooth (D7210), Surgical Extraction of Impacted Teeth (D7220, D7230,7240, D7241) Root Removal (D7250) are limited to 1 time per tooth per lifetime.
28. Placement of Device to Facilitate Eruption of Impacted Tooth (D7283) and Transseptal Fiberotomy/ Supra Crestal Fiberotomy, by report (D7291) are limited to 1 per tooth per lifetime.
29. Tooth Reimplantation and/or Transplantation Services (D7270) are limited to 1 per site per lifetime.
30. Exposure of an Unerupted Tooth (D7280) is limited to 1 time per tooth per lifetime.
31. Mobilization of erupted or malpositioned tooth to aid eruption (D7282) is limited to 1 time per tooth per lifetime.
32. Biopsy (D7286) is limited to 1 biopsy per site per visit.
33. Surgical Incision (D7510-D7511) is limited to 1 time per site per visit.
34. Excision of Hyperplastic Tissue or Pericoronal Gingivia (D7970 and D7971) is limited to 1 per site per consecutive 36 months.
35. 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.
36. Occlusal Guard Adjustments (D9943) are limited to those done more than 12 months after the initial insertion and limited to 1 per consecutive 6 months
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.