Dental Benefit Schedule

COVERED SERVICES
TYPE I SERVICES **DIAGNOSTIC AND PREVENTIVE**
Routine Evaluations (exams limited to twice per Calendar Year)
Limited Oral Evaluation - problem-focused/emergency
Detailed and Extensive Oral Evaluation - problem-focused (exam limited to specialists only, i.e. Periodontal Exam)
Intraoral Radiograph - Complete Series or Panoramic Survey Film (limited to one (1) or the other, once every (3) Calendar Years)
Intraoral or Extraoral Radiographs
Bitewing Radiographs - (limited to twice per Calendar Year)
Cephalometric film
Oral/facial images, Pulp Vitality Tests and Diagnostic Casts
Prophylaxis, Adult or Child (limited to twice per Calendar Year)
Topical Application of Fluoride, under the age of 19 (limited to once per Calendar Year)
Sealant – per tooth, limited to molars (allowed once in any three Calendar Years, under the age of 19)
Space Maintenance Appliance NOTE: Coverage for Space Maintainers is limited to Insureds under the age of nineteen (19) and includes all adjustments within six (6) months after installation. Allowed for the purpose of maintaining spaces created by extraction of primary teeth or unerupted teeth.
Recementation of Space Maintainer
TYPE II SERVICES **RESTORATIVE** (includes local anesthesia and routine postoperative care)
Restoration/Amalgam - per filling (anterior & posterior teeth)
Restoration/Composite – per filling (anterior & posterior teeth)
Recementation of Inlay, Crown or Bridge
Sedative Filling

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Pin Retention – per tooth, in addition to crown
Post Removal (not in conjunction with endodontic therapy)
Prefabricated Crown – per tooth (limited to under age 19)
TYPE II SERVICES **ENDODONTICS** (includes local anesthesia and routine postoperative care)
Pulp Cap – excluding final restoration
Therapeutic Pulpotomy, excluding final restoration
Pulpal Therapy, per primary tooth
Root Canal Therapy – initial or re-treatment, per tooth NOTE: Root Canals include intra-operative radiographs; excludes final restoration.
Apexification/Recalcification - per visit
Apicoectomy/Periradicular surgery – one or first root
Apicoectomy/Periradicular surgery – each additional root
Retrograde Filling - per root
Root Amputation - per root
Hemisection (including root removal) not including root canal therapy
TYPE II SERVICES **PERIODONTICS** (includes local anesthesia and routine postoperative care)
Gingivectomy or Gingivoplasty - per quadrant
Gingivectomy or Gingivoplasty - per tooth
Gingival Curettage, surgical - per quadrant
Gingival Flap Procedure (including Root Planing) - per quadrant
Clinical Crown Lengthening
Osseous Surgery - (including flap entry and closure) – per quadrant
Free Soft Tissue Graft Procedure (including donor site surgery)
Periodontal Scaling/Root Planing - per quadrant (limited to once per quadrant per Calendar Year)

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Full Mouth Debridement (limited to once in three (3) Calendar Years)
Periodontal Maintenance Procedure - following Active Therapy (limited to once in any three(3) month period)
TYPE II SERVICES **ORAL SURGERY** (includes local anesthesia and routine postoperative care)
Simple Extraction – per tooth
Surgical Extraction – per tooth
Surgical Exposure of impacted or unerupted tooth – per tooth
Alveoloplasty - per quadrant
Removal of Exostosis – per site
Incision and Drainage of Abscess
Frenulectomy
TYPE II SERVICES **ADJUNCTIVE GENERAL SERVICES** (includes local anesthesia and routine postoperative care)
Excision of hyperplastic tissue – per arch
Sectioning of a bridge, to enable extraction of an abutment tooth
Adjustment to Denture or Partial Denture, per appliance, per visit
Repair to Denture or Partial Denture, per repair, per appliance
Palliative (Emergency) treatment of dental pain - minor procedures
General Anesthesia or Intravenous Sedation when administered by the dentist in the office (when in connection with a surgical extraction or surgical procedure, or when Medically Necessary)
Analgesia, anxiolysis, inhalation of nitrous oxide (limited to a child under the age of 8, when Medically Necessary)
Professional Consultation (diagnostic service provided by dentist other than dentist providing treatment)
Office Visit After Regularly Scheduled Office Hours

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Therapeutic Drug Injection
Other Drugs and/or Medicaments, by report
Application of Desensitizing Medicaments
Behavior management (limited to a child under the age of 8)
Treatment of Complications (post-surgical), unusual circumstances
TYPE III SERVICES **(SUBJECT TO 12 MONTH WAITING PERIOD)** **PROSTHODONTICS – REMOVABLE** (includes local anesthesia and routine postoperative care)
Denture or Partial Denture, per appliance
Rebase Denture or Partial Denture, (limited to once per three (3) Calendar Years, per appliance)
Reline Denture or Partial Denture, chairside process (limited to twice per Calendar Year, per appliance)
Reline Denture or Partial Denture, laboratory process (limited to twice per Calendar Year, per appliance)
Interim Partial Denture, replacing anterior teeth (temporary stayplate/flipper)
Tissue Conditioning (limited to twice per Calendar Year, per appliance)
NOTE: Adjustments are included in the cost of full and immediate dentures, partial dentures, relines and tissue conditionings within the first six (6) months after installation. Relines are allowed twice in a Calendar Year. Precision attachments, overdentures, specialized techniques and characterizations are considered optional and the additional expense shall be borne by the insured. All partials include conventional clasps and rests.
TYPE III SERVICES **(SUBJECT TO 12 MONTH WAITING PERIOD)** **RESTORATIVE AND PROSTHODONTICS – FIXED** (includes local anesthesia and routine postoperative care)
Inlay or Onlay, each
Crown – per tooth
Core Buildup, including pins
Post and Core, in addition to crown

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Temporary Crown, fractured tooth
Crown or Bridge Repair (by report)
Pontic – per tooth
Retainer (inlay/onlay) – per tooth
Retainer (crown/abutment) – per tooth
TYPE III SERVICES **(SUBJECT TO 12 MONTH WAITING PERIOD)** **ORTHODONTICS** **(Limited to under age 19)**
Limited Orthodontic Treatment
Interceptive Orthodontic Treatment
Comprehensive Orthodontic Treatment
Minor Treatment to control Harmful Habits
Pre-Orthodontic Treatment Visit
Periodic Orthodontic Treatment Visits
Repair of Orthodontic appliance or replacement of broken retainer

NOTE: REFER TO THE CERTIFICATE OF COVERAGE FOR LIMITATIONS, EXCLUSIONS, MANAGED CARE REQUIREMENTS AND ADDITIONAL INFORMATION ABOUT THE COVERED SERVICES.