



Deer Park Independent School District

Lincoln Financial Group *Lincoln DentalConnect*SM DHMO Plan

Lincoln Financial Group is proud to offer you this opportunity to enroll for our *Lincoln DentalConnect*SM DHMO plan.

DHMO rates for plan LDCTXV6c

Employee Only: \$13.09

Employee & Spouse: \$25.53

Employee & Child(ren): \$27.62

Employee & Family (Spouse and Children); \$39.93

Please see the attached benefit summary and enrollment form for more information about this valuable Dental plan.

ADA	DESCRIPTION	MEMBER'S COPAYMENT	ADA	DESCRIPTION	MEMBER'S COPAYMENT
DIAGNOSTIC SERVICES			RESTORATIVE SERVICES*		
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D2335	RSN COMPOS-4/> SURF/W/INCISAL ANG	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0	D2390	RESIN COMPOS CROWN ANTERIOR	\$40
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D2391	RESIN COMPOS - 1 SURFACE POSTERIOR	\$40
D0160	DTL&EXT ORAL EVAL - PROB FOCUS RPT	\$0	D2392	RESIN COMPOS - 2 SURFACES POSTERIOR	\$50
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D2393	RESIN COMPOS - 3 SURFACES POSTERIOR	\$70
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D2394	RESIN COMPOS - 4/MORE SURFACES POST	\$90
D0210	INTRAORAL-COMPLETE SERIES	\$0	D2510	INLAY - METALLIC - ONE SURFACE	\$160
D0220	INTRAORAL PERIAPICAL FIRST FILM	\$0	D2520	INLAY - METALLIC - TWO SURFACES	\$160
D0230	INTRAORL PERIAPICAL EA ADD FILM	\$0	D2530	INLAY - METALLIC - 3/MORE SURFACES	\$160
D0240	INTRAORAL - OCCLUSAL FILM	\$0	D2542	ONLAY - METALLIC - TWO SURFACES	\$215
D0250	EXTRAORAL - FIRST FILM	\$0	D2543	ONLAY METALLIC THREE SURFACES	\$215
D0260	EXTRAORAL - EACH ADDITIONAL FILM	\$0	D2544	ONLAY METALLIC FOUR OR MORE SURF	\$215
D0270	BITEWING - SINGLE FILM	\$0	D2610	INLAY - PORCELN/CERAMIC - 1 SURFACE	\$225
D0272	BITEWINGS - TWO FILMS	\$0	D2620	INLAY - PORCELN/CERAMIC - 2 SURF	\$225
D0273	BITEWINGS - THREE FILMS	\$0	D2630	INLAY - PORCELN/CERAM - 3/MORE SURF	\$225
D0274	BITEWINGS - FOUR FILMS	\$0	D2642	ONLAY - PORCELN/CERAMIC - 2 SURF	\$225
D0277	VERTICAL BITEWINGS - 7 TO 8 FILMS	\$0	D2643	ONLAY - PORCELN/CERAMIC - 3 SURF	\$225
D0330	PANORAMIC FILM	\$0	D2644	ONLAY - PORCELN/CERAM - 4/MORE SURF	\$225
D0415	COLLECT MICROORAGNISMS CULT & SENS	\$0	D2650	INLAY-RSN COMPOS COMPOS/RSN-1 SURF	\$225
D0425	CARIES SUSCEPTIBILITY TESTS	\$0	D2651	INLAY-RSN COMPOS COMPOS/RSN-2 SURF	\$225
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20	D2652	INLAY-RSN COMPOS COMPOS/RSN-3/>SURF	\$225
D0460	PULP VITALITY TESTS	\$0	D2662	ONLAY-RSN COMPOS COMPOS/RSN-2 SURF	\$225
D0470	DIAGNOSTIC CASTS	\$0	D2663	ONLAY-RSN COMPOS COMPOS/RSN-3 SURF	\$225
D0472	ACCESS TISS-GROSS EXAM-PREP & REPRT	\$0	D2664	ONLAY-RSN COMPOS COMPOS/RSN-4/>	\$225
D0473	ACCESS TISS-GROSS/MICRO-PREP/REPRT	\$0	D2710	CROWN RESINBASED COMPOSITE INDIRECT	\$135
D0474	ACSS TISS GR&MIC SURG MARG PREP/RPT	\$0	D2712	CROWN 3/4 RESNBASED COMPOS INDIRECT	\$135
D0999	OFFICE VISIT FEE - PER VISIT	\$5	D2720	CROWN - RESIN WITH HIGH NOBLE METAL*	\$225
PREVENTIVE SERVICES			D2721	CROWN - RESIN W/PREDOM BASE METAL	\$225
D1110	PROPHYLAXIS - ADULT ¹	\$0	D2722	CROWN - RESIN WITH NOBLE METAL*	\$225
-----	PROPHYLAXIS - ADULT ¹ Add. Prophy within 6 months	\$25	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$285
D1120	PROPHYLAXIS - CHILD ¹	\$0	D2750	CROWN - PORCELN FUSED HI NOBLE METL*	\$225
-----	PROPHYLAXIS - CHILD ¹ Add. Prophy within 6 months	\$25	D2751	CROWN-PORCELN FUSD PREDOM BASE METL	\$225
D1203	TOP FLUORIDE - CHILD	\$0	D2752	CROWN - PORCELAIN FUSED NOBLE METAL *	\$225
D1204	TOP FLUORIDE - ADULT	\$0	D2780	CROWN - 3/4 CAST HIGH NOBLE METAL*	\$225
D1206	TOP FLUORIDE; TX APPL MOD-HI RISK	\$0	D2781	CROWN - 3/4 CAST PREDOM BASE METL	\$225
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0	D2782	CROWN - 3/4 CAST NOBLE METAL *	\$225
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$225
D1330	ORAL HYGIENE INSTRUCTIONS	\$0	D2790	CROWN - FULL CAST HIGH NOBLE METAL*	\$225
D1351	SEALANT - PER TOOTH	\$5	D2791	CROWN - FULL CAST PREDOM BASE METL	\$225
D1510	SPACE MAINTAINER - FIXED-UNILATERAL	\$25	D2792	CROWN - FULL CAST NOBLE METAL *	\$225
D1515	SPACE MAINTAINER - FIXED-BILATERAL	\$25	D2794	CROWN TITANIUM *	\$225
D1520	SPACE MAINTAINER - REMOVABLE-UNI	\$45	D2910	RECEMENT INLAY ONLAY/PART COV REST	\$0
D1525	SPACE MAINTAINER - REMOVABLE-BIL	\$45	D2915	RECEMENT CAST/PREFAB POST & CORE	\$0
D1550	RECEMENTATION OF SPACE MAINTAINER	\$10	D2920	RECEMENT CROWN	\$0
D1555	REMOVAL OF FIXED SPACE MAINTAINER	\$10	D2930	PRFABR STAINLESS STEEL CROWN-PRIM	\$40
RESTORATIVE SERVICES*			D2931	PRFABR STAINLESS STEEL CROWN-PERM	\$40
D2140	AMALGAM-ONE SURFACE PRIMARY/PERM	\$0	D2932	PREFABRICATED RESIN CROWN	\$35
D2150	AMALGAM-TWO SURFACES PRIMARY/PERM	\$0	D2933	PRFABR STNLSS STEEL CROWN RSN WINDOW	\$40
D2160	AMALGAM-3 SURFACES PRIMARY/PERM	\$0	D2940	PROTECTIVE RESTORATION	\$0
D2161	AMALGAM-FOUR/MORE SURF PRIM/PERM	\$0	D2950	CORE BUILDUP INCLUDING ANY PINS	\$40
D2330	RESIN COMPOS - ONE SURFACE ANTERIOR	\$0	D2951	PIN RETN - PER TOOTH ADDITION REST	\$0
D2331	RESIN COMPOS - 2 SURFACES ANTERIOR	\$0	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$70
D2332	RESIN COMPOS - 3 SURFACES ANTERIOR	\$0	D2953	EA ADD INDIRECT FAB POST SAME TOOTH	\$70

ADA	DESCRIPTION	MEMBER'S COPAYMENT	ADA	DESCRIPTION	MEMBER'S COPAYMENT
D2954	PREFABR POST&CORE ADDITION CROWN	\$25		REMOVEABLE PROSTHODONTICS SERVICES*	
D2955	POST REMOVAL	\$10	D5211	MAX PARTIAL DENTURE - RESIN BASE	\$295
D2957	EA ADD PREFABR POST - SAME TOOTH	\$25	D5212	MAND PARTIAL DENTUR - RESIN BASE	\$295
D2970	TEMPORARY CROWN	\$0	D5213	MAX PART DENTUR-CAST METL W/RSN	\$315
D2971	ADD PROC NEW CROWN XST PART DENTURE	\$50	D5214	MAND PART DENTUR- CAST METL W/RSN	\$315
	ENDODONTIC SERVICES		D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$315
D3110	PULP CAP - DIRECT	\$0	D5226	MANDIBULAR PART DENTURE FLEX BASE	\$315
D3120	PULP CAP - INDIRECT	\$0	D5281	REMV UNI PART DENTUR-1 PC CAST METL	\$275
D3220	TX PULPOT-CORONL DENTNOCEMENTL JUNC	\$0	D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$5
D3221	PULPAL DEBRID PRIMARY&PERM TEETH	\$20	D5411	ADJUST COMPLETE DENTUR - MANDIBULAR	\$5
D3230	PULPAL THERAPY - ANT PRIMARY TOOTH	\$35	D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$5
D3240	PULPAL THERAPY - POST PRIMARY TOOTH	\$35	D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$5
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH(XCLD FINL REST)	\$85	D5510	REPAIR BROKEN COMPLETE DENTURE BASE	\$35
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH (XCLD FINL REST)	\$135	D5520	REPL MISS/BROKEN TEETH-CMPL DENTUR	\$35
D3330	ENDODONTIC THERPAY, MOLAR (XCLD FINAL RESTORATION)	\$250	D5610	REPAIR RESIN DENTURE BASE	\$35
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D5620	REPAIR CAST FRAMEWORK	\$35
D3332	INCML ENDO TX;INOP UNRSTR/FX TOOTH	\$85	D5630	REPAIR OR REPLACE BROKEN CLASP	\$35
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$85	D5640	REPLACE BROKEN TEETH - PER TOOTH	\$35
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$105	D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$35
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$155	D5660	ADD CLASP EXISTING PARTIAL DENTURE	\$35
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$270	D5670	REPL ALL TEETH&ACRYLC FRMEWRK MAX	\$155
D3351	APEXIFICAT/RECALCIFICAT/PULPAL REGENERTN - INTIAL VST	\$70	D5671	REPL ALL TEETH&ACRYLC FRMEWRK MAND	\$155
D3352	APEXIFICAT/RECALC/PULP REGEN-INTRM MED REPLACMNT	\$50	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$85
D3353	APEXIFICAT/RECALCIFICAT-FINAL VISIT	\$60	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$85
D3410	APICOECT/PERIRADICULAR SURG - ANT	\$105	D5720	REBASE MAXILLARY PARTIAL DENTURE	\$85
D3421	APICOECT/PERIRADICULR SURG-BICUSPID	\$105	D5721	REBASE MANDIBULAR PARTIAL DENTURE	\$85
D3425	APICOECT/PERIRADICULAR SURG - MOLAR	\$105	D5730	RELIN CMPL MAXIL DENTURE CHAIRSIDE	\$45
D3426	APICOECTOMY/PERIRADICULAR SURGERY	\$45	D5731	RELIN CMPL MAND DENTURE CHAIRSIDE	\$45
D3430	RETROGRADE FILLING - PER ROOT	\$50	D5740	RELIN MAXIL PART DENTURE CHAIRSIDE	\$45
D3450	ROOT AMPUTATION - PER ROOT	\$105	D5741	RELIN MAND PART DENTURE CHAIRSIDE	\$45
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15	D5750	RELIN CMPL MAXIL DENTURE LAB	\$65
D3920	HEMISECTION NOT INCL RC THERAPY	\$85	D5751	RELIN CMPL MAND DENTRUE LABORATORY	\$65
D3950	CANAL PREP&FIT PREFORMED DOWEL/POST	\$12	D5760	RELIN MAXIL PART DENTURE LAB	\$65
	PERIODONTIC SERVICES		D5761	RELIN MAND PART DENTURE LABORATORY	\$65
D4210	GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	\$100	D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$105
D4211	GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	\$65	D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$105
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$155	D5850	TISSUE CONDITIONING MAXILLARY	\$10
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$105	D5851	TISSUE CONDITIONING MANDIBULAR	\$10
D4245	APICALLY POSITIONED FLAP	\$155		FIXED PROSTHODONTICS SERVICES*	
D4249	CLIN CROWN LEN - HARD TISSUE	\$175	D6210	PONTIC - CAST HIGH NOBLE METAL*	\$225
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$275	D6211	PONTIC - CAST PREDOM BASE METAL	\$225
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$165	D6212	PONTIC - CAST NOBLE METAL *	\$225
D4263	BONE REPLCMT GRAFT - 1 SITE QUAD	\$155	D6214	PONTIC TITANIUM *	\$225
D4264	BN REPLCMT GRAFT - EA ADD SITE QUAD	\$105	D6240	PONTIC-PORCELN FUSED HI NOBLE METL *	\$225
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$190	D6241	PONTIC-PORCLN FUSD PREDOM BASE METL	\$225
D4271	FREE SOFT TISSUE GRAFT PROCEDURE	\$205	D6242	PONTIC - PORCELN FUSED NOBLE METAL *	\$225
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	\$85	D6245	PONTIC - PORCELAIN/CERAMIC	\$285
D4341	PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	\$40	D6250	PONTIC - RESIN W/HIGH NOBLE METAL *	\$225
D4342	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	\$40	D6251	PONTIC RESIN W/PREDOM BASE METAL	\$225
D4355	FULL MOUTH DEBRID COMP EVAL&DX	\$45	D6252	PONTIC RESIN W/NOBLE METAL *	\$225
D4381	LOC DEL ANTIMICROBIAL AGT TOOTH BR	\$50	D6600	INLAY-PORCELAIN/CERAMIC 2 SURFACES	\$245
D4910	PERIODONTAL MAINTENANCE	\$40	D6601	INLAY - PORCELN/CERAMIC 3/MORE SURF	\$245
D4920	UNSCHEDULED DRESSING CHANGE	\$0	D6602	INLAY - CAST HI NOBLE METAL 2 SURF	\$160
	REMOVEABLE PROSTHODONTICS SERVICES*		D6603	INLAY-CAST HI NOBLE METL 3/> SURF	\$160
D5110	COMPLETE DENTURE - MAXILLARY	\$285	D6604	INLAY-CAST PREDOM BASE METL 2 SURF	\$160
D5120	COMPLETE DENTURE - MANDIBULAR	\$285	D6605	INLAY-CAST PREDOM BASE METL 3/>SURF	\$160
D5130	IMMEDIATE DENTURE - MAXILLARY	\$305	D6606	INLAY - CAST NOBLE METAL 2 SURFACES	\$160
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$305	D6607	INLAY - CAST NOBLE METL 3/MORE SURF	\$160

ADA	DESCRIPTION	MEMBER'S COPAYMENT	ADA	DESCRIPTION	MEMBER'S COPAYMENT
FIXED PROSTHODONTICS SERVICES*			ORAL SURGERY SERVICES		
D6608	ONLAY - PORCELN/CERAMIC 2 SURFACES	\$255	D7473	REMOVAL OF TORUS MANDIBULARIS	\$50
D6609	ONLAY - PORCELN/CERAMIC 3/MORE SURF	\$255	D7485	SURGICAL RDOC OSSEOUS TUBEROSITY	\$50
D6610	ONLAY - CAST HI NOBLE METAL 2 SURF	\$160	D7510	I&D ABSCESS-INTRAORAL SOFT TISS	\$25
D6611	ONLAY-CAST HI NOBLE METL 3/> SURF	\$160	D7511	I & D ABS INTRAORAL SOFT TISS COMP	\$25
D6612	ONLAY-CAST PREDOM BASE METL 2 SURF	\$160	D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25
D6613	ONLAY-CAST PREDOM BASE METL 3/>SURF	\$160	D7960	FRENULLECTOMY-ALSO KNOWN AS FRENECTOMY OR FRE- NOTOMY-SEPAR PROCED NOT INCIDENTAL TO ANOTHER	\$40
D6614	ONLAY - CAST NOBLE METAL 2 SURFACES	\$160	D7963	FRENULOPLASTY	\$40
D6615	ONLAY - CAST NOBLE METL 3/MORE SURF	\$160	D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$50
D6624	INLAY TITANIUM	\$225	D7971	EXCISION OF PERICORONAL GINGIVA	\$40
D6634	ONLAY TITANIUM	\$225	D7972	SURGICAL RDOC FIBROUS TUBEROSITY	\$95
D6720	CROWN - RESIN WITH HIGH NOBLE METAL *	\$225	ADJUNCTIVE GENERAL SERVICES		
D6721	CROWN RESIN PREDOM BASE METL-DENTUR	\$225	D9110	PALLIATIVE TX DENTAL PAIN-MINOR PROC	\$10
D6722	CROWN - RESIN WITH NOBLE METAL *	\$225	D9211	REGIONAL BLOCK ANESTHESIA	\$0
D6740	CROWN - PORCELAIN/CERAMIC	\$285	D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0
D6750	CRWN PORCLN FUSD HI NOBL MTL-DENTUR *	\$225	D9215	LOCAL ANESTHESIA	\$0
D6751	CROWN-PORCELN FUSD PREDOM BASE METL	\$225	D9220	DP SEDATION/GEN ANES-1ST 30 MIN	\$145
D6752	CROWN - PORCELAIN FUSED NOBLE METAL *	\$225	D9221	DP SEDAT/GEN ANES-EA ADD 15 MIN	\$65
D6780	CROWN - 3/4 CAST HIGH NOBLE METAL *	\$225	D9241	IV CONSC SEDAT/ANALG -1ST 30 MIN	\$145
D6781	CROWN-3/4 CAST PREDOM BASED METAL	\$225	D9242	IV CONSC SEDAT/ANALG-EA ADD 15 MIN	\$65
D6782	CROWN 3/4 CAST NOBLE METAL-DENTURE *	\$225	D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0
D6783	CROWN 3/4 PORCELAIN/CERAMIC-DENTURE	\$285	D9430	OV OBS - NO OTH SERVICES PERFORMED	\$0
D6790	CROWN FULL CAST HI NOBL METL-DENTUR *	\$225	D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35
D6791	CROWN FULL CAST BASE METAL-DENTURE	\$225	D9450	CASE PRSATION DTL&EXT TX PLANNING	\$0
D6792	CROWN FULL CAST NOBLE METAL-DENTURE *	\$225	D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0
D6794	CROWN TITANIUM *	\$225	D9940	OCCLUSAL GUARD BY REPORT	\$75
D6930	RECEMENT FIXED PARTIAL DENTURE	\$0	D9951	OCCLUSAL ADJUSTMENT - LIMITED	\$20
D6940	STRESS BREAKER	\$105	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$90
D6970	POST&CORE ADD FIX PART DENTURE RET	\$40	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
D6972	PRFAB POST&COR ADD PART DENTUR RETN	\$25	D9999	BROKEN APPOINTMENT	\$20
D6973	CORE BUILD UP RETAIN INCL ANY PINS	\$15	ORTHODONTIC SERVICES		
D6976	EA ADD INDIRECT FAB POST SAME TOOTH	\$45	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSI- TIONAL DENTITION	\$1,895
D6977	EACH ADD PRFAB POST SAME TOOTH	\$45	D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLES- CENT DENTITION	\$1,895
ORAL SURGERY SERVICES			D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	\$1,895
D7111	XTRCT CORONL RMNNTS DECIDUOUS TOOTH	\$0	D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION, AND PLACEMENT OF RETAINERS)	\$300
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$0	D8999	START-UP FEE (INCLUDING EXAM, BEGINNING RECORDS, X-RAYS, TRACING, PHOTOS, AND MODELS)	\$250
D7210	SURG REMOVAL ERUPTED TOOTH	\$25	D8999	POST TREATMENT RECORDS	\$150
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	\$50			
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$75			
D7240	REMOVAL IMPACTED TOOTH - CMPL BONY	\$105			
D7241	REMV IMP TOOTH-CMPL BNY W/SURG COMP	\$125			
D7250	SURG REMOVAL RESIDUAL TOOTH ROOTS	\$30			
D7270	TOOTH REIMPL&/STBL ACC DISPLCD	\$50			
D7280	SURGICAL ACCESS AN UNERUPTED TOOTH	\$85			
D7282	MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	\$90			
D7285	BIOPSY OF ORAL TISSUE HARD	\$125			
D7286	BIOPSY OF ORAL TISSUE SOFT	\$50			
D7288	BRUSH BIOPSY - TRANSEPIHELIAL SAMPLE COLLECTION	\$0			
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	\$35			
D7311	ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	\$10			
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$50			
D7321	ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	\$20			
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$65			
D7472	REMOVAL OF TORUS PALATINUS	\$50			

1. Additional Prophylaxis within 6 months will be based upon the necessity recommended by the provider.

2. Copays listed are also applicable in the specialist office.

* The plan provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, the Covered Person must pay: (a) the Copayment for the inlay, onlay, crown or fixed bridge; and (b) an added charge equal to the actual laboratory cost of the high noble metal, not to exceed \$150.

Dental HMO exclusions and limitations

Limitations of Benefits

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1. Dental Prophylaxis - Limited to 1 time per 6 months
 2. Intraoral -Complete Series (including bitewings) - Limited to 1 time in any 2 year period.
 3. Intraoral Bitewing Radiographs – Limited to 1 series of 4 films in any 6 month period
 4. Fluoride Treatments – Limited to one time per calendar year
 5. Scaling and Root Planing - Limited to 4 quadrants per calendar year.
 6. Periodontal Maintenance - Limited to once every 6 months, following active therapy, exclusive of gross debridement
 7. Removable Prosthetics/Fixed Prosthetics/Crowns, Inlays and Onlays (Major Restorative Services) - Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 years from initial or supplemental placement
 8. Removable Prosthetics/Fixed Prosthetics/Crowns, Inlays and Onlays (Major Restorative Services) - Replacement of complete dentures, and fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
 9. Crowns - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
 10. Crowns – Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
 11. Temporary Crowns – Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
 12. Inlays/Onlays - Retainers/Abutments - Limited to 1 time per tooth per 5 years
 13. Inlays/Onlays – Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth...
 14. Stainless Steel Crowns - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown -primary tooth, are limited to primary anterior teeth.
 15. Crowns and fixed bridges, the maximum benefit within a 12-month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12-month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Charges...
 16. Post and Cores - Covered only for teeth that have had root canal therapy.
 17. Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns Limited to repairs or adjustments performed more than 6 months after the initial insertion.
 18. Intravenous Sedation or General Anesthesia - Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).
 19. Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20. All Specialty Referral Services Must Be: (A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
 - In order for specialty services to be Covered by this plan, the following referral process must be followed:
 - A Covered Person's PCD must coordinate all Dental Services.
 - When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization...
 - If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
 - Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not pre-authorized by us to provide such services.
 - Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

Exclusion of Benefits

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1. Dental Services that are not Necessary. Such decision is an adverse determination, which can be appealed. See your EOC for your appeal options.
2. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services
3. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of Coverage.
4. Any Dental Procedure not directly associated with dental disease.
5. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO)
6. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services
7. Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Primary Care Dentist, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis
10. Removable Prosthetics/Fixed Prosthetics/Crowns, Inlays and Onlays (Major Restorative Services) - The plan provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, the Covered Person must pay: (a) the Copayment for the inlay, onlay, crown or fixed bridge; and (b) an added charge equal to the actual laboratory cost of the high noble metal.
11. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability
12. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction
13. 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
14. Dental Services otherwise Covered under the Contract, but rendered after the date individual Coverage under the Contract terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Contract terminates
15. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval
17. Placement of dental implants, implant-supported abutments and prostheses
18. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
19. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment.
20. Any endodontic, periodontal, crown or bridge abutment procedure or

appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis

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.
22. Relative analgesia (N2O2 - nitrous oxide) is not covered

Orthodontic Exclusions & Limitations

If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the member will be responsible for all costs associated with any orthodontic treatment.

If you terminate coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. The following are not Covered orthodontic benefits:
 - Extractions required for orthodontic purposes
 - Surgical orthodontics or jaw repositioning
 - Myofunctional therapy
 - Cleft palate
 - Micrognathia
 - Macroglossia
 - Hormonal imbalances
 - Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of accident
 - Palatal expansion appliances
 - Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.