UNITED CONCORDIA®

Concordia Plus Schedule of Benefits

Plan University of Pittsburgh Faculty and Staff

Effective 01/01/2020

IMPORTANT INFORMATION ABOUT YOUR PLAN

- This schedule of benefits provides a listing of procedures covered by your plan. For procedures that require a copayment, the amount to be paid is shown in the column titled "Member Pays $." You pay these copayments to the dental office at the time of service.
- You must select a United Concordia Primary Dental Office (PDO) to receive covered services. Your PDO will perform the below procedures or refer you to a specialty care dentist for further care. Treatment by an Out-of-Network dentist is not covered, except as described in the Certificate of Coverage.
- Only procedures listed on this Schedule of Benefits are Covered Services. For services not listed (not covered), You are responsible for the full fee charged by the dentist. Procedure codes and member Copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.
- For a complete description of your plan, please refer to the Certificate of Coverage and the Schedule of Exclusions and Limitations in addition to this Schedule of Benefits.
- If you have questions about your United Concordia Dental Plan, please call our Customer Service Department toll free at 1-877-215-3616 or access our website at www.unitedconcordia.com.

ADA Code	ADA Description	Member Pays $
	CLINICAL ORAL EVALUATIONS	
D0120	Periodic Oral Evaluation - Established Patient	0
D0140	Limited Oral Evaluation - Problem Focused	0
D0145	Oral Evaluation For A Patient Under 3 Years Of Age And Counseling With Primary Caregiver	0
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0
D0170	Re-Evaluation-Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	0
D0180	Comprehensive Periodontal Evaluation	0
	RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)	
D0210	Intraoral - Complete Series Of Radiographic Images	0
D0220	Intraoral- Periapical First Radiographic Image	0
D0230	Intraoral- Periapical Each Additional Radiographic Image	0
D0240	Intraoral - Occlusal Radiographic Image	0
D0270	Bitewing - Single Radiographic Image	0
D0272	Bitewings - Two Radiographic Images	0
D0273	Bitewings - Three Radiographic Images	0
D0274	Bitewings - Four Radiographic Images	0
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0
D0330	Panoramic Radiographic Image	0
D0340	2D Cephalometric Radiographic Image - Acquisition, Measurement And Analysis	0
	TESTS AND EXAMINATIONS	
D0460	Pulp Vitality Tests	0
D0470	Diagnostic Casts	0
	ORAL PATHOLOGY LABORATORY	
D0601	Caries Risk Assessment And Documentation, With A Finding Of Low Risk	0

ADA Code	ADA Description	Member Pays $
	ORAL PATHOLOGY LABORATORY	
D0602	Caries Risk Assessment And Documentation, With A Finding Of Moderate Risk	0
D0603	Caries Risk Assessment And Documentation, With A Finding Of High Risk	0
	DENTAL PROPHYLAXIS	
D1110	Prophylaxis, Adult	0
D1120	Prophylaxis, Child	0
	TOPICAL FLUORIDE TREATMENT (office procedure)	
D1206	Topical Application Of Fluoride Varnish	0
D1208	Topical Application Of Flouride - Excluding Varnish	0
	OTHER PREVENTIVE SERVICES	
D1330	Oral Hygiene Instruction	0
D1351	Sealant - Per Tooth	0
D1353	Sealant Repair - Per Tooth	0
D1354	Interim Caries Arresting Medicament Application - Per Tooth	15
	SPACE MAINTENANCE (passive appliances)	
D1510	Space maintainer - fixed, unilateral - per quadrant	0
D1516	Space Maintainer - Fixed - bilateral, maxillary	0
D1517	Space Maintainer - Fixed - bilateral, mandibular	0
D1520	Space maintainer - removable, unilateral - per quadrant	0
D1526	Space Maintainer - Removable - bilateral, maxillary	0
D1527	Space Maintainer - Removable - bilateral, mandibular	0
D1556	Removal of fixed unilateral space maintainer - per quadrant	0
D1557	Removal of fixed unilateral space maintainer - maxillary	0
D1558	Removal of fixed unilateral space maintainer - mandibular	0

ADA Code	ADA Description	Member Pays $	
	SPACE MAINTENANCE (passive appliances)		
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	0	
	AMALGAM RESTORATIONS (including polishing)		
D2140	Amalgam - One Surface, Primary Or Permanent	0	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0	
	RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
D2330	Resin-Based Composite - One Surface, Anterior	0	
D2331	Resin-Based Composite - Two Surfaces, Anterior	0	
D2332	Resin-Based Composite - Three Surfaces, Anterior	0	
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	0	
D2390	Resin-Based Composite Crown, Anterior	0	
D2391	Resin-Based Composite - One Surface, Posterior	0	
D2392	Resin-Based Composite - Two Surfaces, Posterior	0	
D2393	Resin-Based Composite - Three Surfaces, Posterior	0	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0	
	INLAY/ONLAY RESTORATIONS		
D2510	Inlay - Metallic - One Surface	190	◆
D2520	Inlay - Metallic - Two Surfaces	204	◆
D2530	Inlay - Metallic - Three Or More Surfaces	225	◆
D2542	Onlay - Metallic-Two Surfaces	264	◆
D2543	Onlay - Metallic - Three Surfaces	279	◆
D2544	Onlay - Metallic - Four Or More Surfaces	295	◆
	CROWNS - SINGLE RESTORATIONS ONLY		
D2710	Crown-Resin-Based Composite (Indirect)	85	
D2712	Crown - 3/4 Resin-Based Composite (Indirect)	88	
D2740	Crown, Porcelain/Ceramic	277	□
D2750	Crown, Porcelain Fused To High Noble Metal	267	◆
D2751	Crown-Porcelain Fused To Predominantly Base Metal	237	
D2752	Crown, Porcelain Fused To Noble Metal	255	◆
D2753	Crown - porcelain fused to titanium and titanium alloys	255	
D2780	Crown - 3/4 Cast High Noble Metal	273	◆
D2781	Crown - 3/4 Cast Predominantly Base Metal	273	
D2782	Crown - 3/4 Cast Noble Metal	273	◆
D2783	Crown - 3/4 Porcelain/Ceramic	273	□
D2790	Crown, Full Cast High Noble Metal	260	◆
D2791	Crown - Full Cast Predominantly Base Metal	235	
D2792	Crown, Full Cast Noble Metal	245	◆
D2794	Crown - titanium and titanium alloys	237	
D2799	Provisional Crown - Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression	0	
	OTHER RESTORATIVE SERVICES		

ADA Code	ADA Description	Member Pays $
	OTHER RESTORATIVE SERVICES	
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	0
D2915	Re-Cement Or Rebond Indirectly Fabricated Or Prefabricated Post And Core	0
D2920	Re-Cement Or Re-Bond Crown	0
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	0
D2940	Protective Restoration	0
D2949	Restorative Foundation For An Indirect Restoration	0
D2950	Core Buildup Including Any Pins When Required	0
D2951	Pin Retention - Per Tooth, In Addition To Restoration	0
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	83
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	45
D2954	Prefabricated Post And Core In Addition To Crown	0
D2957	Each Additional Prefabricated Post - Same Tooth	0
D2971	Additional Procedures To Construct New Crown Under Existing Partial Denture Framework	25
	PULP CAPPING	
D3110	Pulp Cap - Direct (Excluding Final Restoration)	0
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	0
	PULPOTOMY	
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	0
D3221	Pulpal Debridement, Primary And Permanent Teeth	0
D3222	Partial Pulpotomy For Apexogenesis-Permanent Tooth With Incomplete Root Development	0
	ENDODONTIC THERAPY ON PRIMARY TEETH	
D3230	Pulpal Therapy (Resorbable Filling)-Anterior, Primary Tooth (Excluding Final Restoration)	0
D3240	Pulpal Therapy (Resorbable Filling)-Posterior, Primary Tooth (Excluding Final Restoration)	0
	ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	0
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	148
	ENDODONTIC RETREATMENT	
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	0
D3347	Retreatment Or Previous Root Canal Therapy - Premolar	0
D3348	Retreatment Of Previous Root Canal Therapy - Molar	239
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy - Anterior	109

ADA Code	ADA Description	Member Pays $
	APICOECTOMY/PERIRADICULAR SERVICES	
D3421	Apicoectomy - Premolar (First Root)	155
D3425	Apicoectomy - Molar (First Root)	166
D3426	Apicoectomy (Each Additional Root)	68
D3427	Periradicular Surgery Without Apicoectomy	182
D3450	Root Amputation - Per Root	96
	OTHER ENDODONTIC PROCEDURES	
D3920	Hemisection (Including Any Root Removal) Not Including Root Canal Therapy	82
D3950	Canal Preparation And Fitting Of Preformed Dowel Or Post	0
	SURGICAL SERVICES (including usual postoperative care)	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	71
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	30
D4212	Gingivectomy Or Gingivoplasty To Allow Access For Restorative Procedure, Per Tooth	0
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	90
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	38
D4245	Apically Positioned Flap	121
D4249	Clinical Crown Lengthening-Hard Tissue	147
D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	164
D4261	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	74
D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed In Conjunction With Surgical Procedures In The Same Anatomical Area)	102
	NON-SURGICAL PERIODONTAL SERVICES	
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	0
D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation - Full Mouth, After Oral Evaluation	0
D4355	Full Mouth Debridement To Enable a Comprehensive Oral Evaluation And Diagnosis on a Subsequent Visit	0
D4381	Localized Delivery Of Antimicrobial Agents Via Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth	100
	OTHER PERIODONTAL SERVICES	
D4910	Periodontal Maintenance	0
D4921	Gingival Irrigation - Per Quadrant	25
	COMPLETE DENTURES (including routine post delivery care)	
D5110	Complete Denture - Maxillary	275
D5120	Complete Denture - Mandibular	275
D5130	Immediate Denture - Maxillary	300
D5140	Immediate Denture - Mandibular	300

ADA Code	ADA Description	Member Pays $
	PARTIAL DENTURES (including routine post-delivery care)	
D5211	Maxillary Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests And Teeth)	235
D5212	Mandibular Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests And Teeth)	279
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	316
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	315
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	235
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	279
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	316
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	315
D5225	Maxillary Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	363
D5226	Mandibular Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	362
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	195
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	195
D5284	Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	195
D5286	Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant	195
	ADJUSTMENTS TO DENTURES	
D5410	Adjust Complete Denture - Maxillary	0
D5411	Adjust Complete Denture - Mandibular	0
D5421	Adjust Partial Denture - Maxillary	0
D5422	Adjust Partial Denture - Mandibular	0
	REPAIRS TO COMPLETE DENTURES	
D5511	Repair Broken Complete Denture Base, Mandibular	0
D5512	Repair Broken Complete Denture Base, Maxillary	0
D5520	Replace Missing Or Broken Teeth-Complete Denture (Each Tooth)	0
	REPAIRS TO PARTIAL DENTURES	
D5611	Repair Resin Partial Denture Base, Mandibular	0
D5612	Repair Resin Partial Denture Base, Maxillary	0
D5621	Repair Cast Partial Framework, Mandibular	0
D5622	Repair Cast Partial Framework, Maxillary	0
D5630	Repair Or Replace Broken Retentive Clasping Materials - Per Tooth	0

ADA Code	ADA Description	Member Pays $	
	REPAIRS TO PARTIAL DENTURES		
D5640	Replace Broken Teeth-Per Tooth	0	
D5650	Add Tooth To Existing Partial Denture	0	
D5660	Add Clasp To Existing Partial Denture - Per Tooth	0	
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	206	
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	205	
	DENTURE REBASE PROCEDURES		
D5710	Rebase Complete Maxillary Denture	0	
D5711	Rebase Complete Mandibular Denture	0	
D5720	Rebase Maxillary Partial Denture	0	
D5721	Rebase Mandibular Partial Denture	0	
	DENTURE RELINE PROCEDURES		
D5730	Reline Complete Maxillary Denture (Chairside)	0	
D5731	Reline Complete Mandibular Denture (Chairside)	0	
D5740	Reline Maxillary Partial Denture (Chairside)	0	
D5741	Reline Mandibular Partial Denture (Chairside)	0	
D5750	Reline Complete Maxillary Denture (Laboratory)	0	
D5751	Reline Complete Mandibular Denture (Laboratory)	0	
D5760	Reline Maxillary Partial Denture (Laboratory)	0	
D5761	Reline Mandibular Partial Denture (Laboratory)	0	
	OTHER REMOVABLE PROSTHETIC SERVICES		
D5850	Tissue Conditioning, Maxillary	33	
D5851	Tissue Conditioning, Mandibular	33	
	FIXED PARTIAL DENTURE PONTICS		
D6205	Pontic - Indirect Resin Based Composite	232	
D6210	Pontic-Cast High Noble Metal	263	◆
D6211	Pontic-Cast Predominatly Base Metal	241	
D6212	Pontic-Cast Noble Metal	253	◆
D6214	Pontic - titanium and titanium alloys	241	
D6240	Pontic-Porcelain Fused To High Noble Metal	264	◆
D6241	Pontic-Porcelain Fused To Predominantly Base Metal	232	
D6242	Pontic-Porcelain Fused To Noble Metal	253	◆
D6243	Pontic - porcelain fused to titanium and titanium alloys	253	
D6245	Pontic - Procelain/Ceramic	232	□
	FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6710	Retainer Crown - Indirect Resin Based Composite	235	
D6740	Retainer Crown - Porcelain/Ceramic	235	□
D6750	Retainer Crown, Porcelain Fused To High Noble Metal	266	◆
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	235	
D6752	Retainer Crown, Porcelain Fused To Noble Metal	255	◆
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	255	
D6780	Retainer Crown, 3/4 Cast High Noble Metal	260	◆
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	260	
D6782	Retainer Crown - 3/4 Cast Noble Metal	260	◆

ADA Code	ADA Description	Member Pays $	
	FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	260	□
D6784	Retainer crown 3/4 - titanium and titanium alloys	260	
D6790	Retainer Crown, Full Cast High Noble Metal	264	◆
D6791	Retainer Crown, Full Cast Predominantly Base Metal	234	
D6792	Retainer Crown, Full Cast Noble Metal	258	◆
D6794	Retainer crown - titanium and titanium alloys	234	
	OTHER FIXED PARTIAL DENTURE SERVICES		
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	34	
	EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D7111	Extraction, Coronal Remnants - Primary Tooth	0	
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	0	
	SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D7210	Extraction, Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth, And Including Elevation Of Mucoperiosteal Flap If Indicated	47	
D7220	Removal Of Impacted Tooth - Soft Tissue	65	
D7230	Removal Of Impacted Tooth - Partially Bony	89	
D7240	Removal Of Impacted Tooth - Completely Bony	103	
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	110	
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	49	
D7251	Coronectomy-Intentional Partial Tooth Removal	103	
	OTHER SURGICAL PROCEDURES		
D7280	Exposure Of An Unerupted Tooth	89	
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	24	
D7288	Brush Biopsy - Transepithelial Sample Collection	45	
	ALVEOLOPLASTY (surgical preparation of ridge for dentures)		
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	45	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	55	
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	24	
	OTHER REPAIR PROCEDURES		
D7960	Frenulectomy - Also Known As Frenectomy Or Frenotomy - Separate Procedure Not Incidental To Another Procedure	81	
D7963	Frenuloplasty	40	
	LIMITED ORTHODONTIC TREATMENT		
D8010	Limited Orthodontic Treatment Of Primary Dentition	480	
D8020	Limited Orthodontic Treatment Of Transitional Dentition	605	
D8030	Limited Orthodontic Treatment Of Adolescent Dentition	857	
	INTERCEPTIVE ORTHODONTIC TREATMENT		

ADA Code	ADA Description	Member Pays $
	INTERCEPTIVE ORTHODONTIC TREATMENT	
D8050	Interceptive Orthodontic Treatment Of Primary Dentition	706
D8060	Interceptive Orthodontic Treatment Of Transitional Dentition	999
	COMPREHENSIVE ORTHODONTIC TREATMENT	
D8070	Comprehensive Orthodontic Treatment Of Transitional Dentition	1923
D8080	Comprehensive Orthodontic Treatment Of Adolescent Dentition	1989
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D8210	Removable Appliance Therapy For Control Of Harmful Habits	324
D8220	Fixed Appliance Therapy For Control Of Harmful Habits	360
	OTHER ORTHODONTIC SERVICES	
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	96
D8680	Orthodontic Retention (Removal Of Appliances, Construction And Placement Of Retainer(S)	247
	UNCLASSIFIED TREATMENT	
D9110	Palliative (Emergency) Treatment Of Dental Pain, Minor Procedures	0
	ANESTHESIA	
D9219	Evaluation For Moderate Sedation, Deep Sedation Or General Anesthesia	0
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	34
D9223	Deep Sedation/General Anesthesia - Each Subsequent 15 Mintue Increment	34
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	34
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute Increment	34
	PROFESSIONAL CONSULTATION	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician Other Than Requesting Dentist Or Physician	0
	PROFESSIONAL VISITS	
D9430	Office Visit For Observation (During Regularly Scheduled Hours) - No Other Services Performed	0
	MISCELLANEOUS SERVICES	
D9932	Cleaning And Inspection Of Removable Complete Denture, Maxillary	0
D9933	Cleaning And Inspection Of Removable Complete Denture, Mandibular	0
D9934	Cleaning And Inspection Of Removable Partial Denture, Maxillary	0
D9935	Cleaning And Inspection Of Removable Partial Denture, Mandibular	0
D9986	Missed Appointment	15
D9987	Cancelled appointment	15
D9990	Certified translation or sign-language services - per visit	0
D9995	Teledentistry - Synchronous; Real-Time Encounter	0
D9996	Teledentistry - Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review	0

ADA Code	ADA Description	Member Pays $
	MISCELLANEOUS SERVICES	
D9997	Dental care management - patients with special health care needs	0

FOOTNOTES

◆ Charges for the use of precious (high noble) or semi precious (noble) metal are not included in the copayment for crowns, bridges, pontics, inlays and onlays. The decision to use these materials is a cooperative effort between the provider and the patient, based on the professional advice of the provider. Providers are expected to charge no more than an additional $125 for these materials.

◘ Charges for lab fees are not covered and therefore are not included in the copayment for crowns, bridges, pontics, inlays and onlays. The decision to charge lab fees must be agreed upon between the member and the provider, with the member signed approval. Providers are expected to charge no more than an additional $125 enhancement lab fee for these services.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

Except as specifically provided in this Certificate, Schedules of Benefits, Riders to the Certificate, no coverage will be provided for services, supplies or charges:

1. Not specifically listed in the Schedule of Benefits as a Covered Service.

2. Provided to Members by Out-of-Network Dentists except when immediate dental treatment is required as a result of a Dental Emergency occurring more than 50 miles from the Member's home.

3. Which in the opinion of the treating dentist, or the Company, are not clinically necessary, or do not have a reasonable, favorable prognosis.

   This exclusion does not apply to Group Contracts and Certificates issued and delivered in Maryland.

4. That are necessary due to lack of cooperation with Primary Dental Office, or failure to comply with a professionally prescribed Treatment Plan.

5. Started or incurred prior to the Member's Effective Date of Coverage with the Company or started after the Termination Date of Coverage with the Company.

6. For consultations by a Specialty Care Dentist for services not specifically listed on the Schedule of Benefits as a Covered Service.

7. Services or supplies that are not deemed generally accepted standards of dental treatment.

8. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

   For Group Contracts and Certificates issued and delivered in Missouri and New Jersey, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

   For Group Contracts and Certificates issued and delivered in Texas, only services that are the responsibility of the employer's liability insurance, or for treatment of any automobile related injury shall be excluded from this Plan.

   For Group Contracts and Certificates delivered in Maryland, only services related to Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

   For Group Contracts and Certificates issued and delivered in Florida, only services that are paid by Workers' Compensation or the employer's liability insurance, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy shall be excluded from this Plan.

9. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

   This exclusion does not apply to Group Contracts and Certificates issued in Pennsylvania if the dental condition is as a result of an accidental injury.

10. That restore tooth structure due to attrition, erosion or abrasion.

11. For periodontal splinting of teeth by any method.

12. For replacement of lost, missing, stolen or damaged prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device.

13. For replacement of existing dentures that are, or can be made serviceable.

14. For prosthetic reconstruction or other services which require a prosthodontist.

15. For assistant at surgery.

16. For elective procedures, including prophylactic extraction of third molars.

17. For congenital mouth malformations or skeletal imbalances, including, but not limited to, treatment related to cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery, including orthodontic treatment, and oral and maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth. This exclusion shall not apply to newly born children of Members as defined in the definition of Dependent.

    For Group Contracts and Certificates issued and delivered in Kentucky and Pennsylvania, this exclusion shall not apply to newly born children of Members as defined under the definition of Dependent including newly adoptive children, regardless of age.

    For Group Contracts and Certificates issued and delivered in Indiana and New Jersey, this exclusion

shall not apply to newly born children of Members as defined under the definition of Dependent.

For Group Contracts and Certificates issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

For Group Contracts and Certificates issued in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of TMD rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease, or injury and such procedures are covered under a Rider to the Certificate or the Schedule of Benefits.

18. For diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint.

19. For implants, surgical insertion and/or removal of, and any appliances and/or crowns attached to implants.

20. For the following, which are not included as orthodontic benefits: retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient non-cooperation, repair of orthodontic appliances, replacement of lost or stolen appliances, special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders), myofunctional therapy, cases involving orthognathic surgery, extractions for orthodontic purposes, and treatment in excess of 24 months.

    For Group Contracts and Certificates issued in Florida, this exclusion does not apply to diagnostic and surgical dental (not medical) procedures for treatment of TMD rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease, or injury and such procedures are covered under a Rider to the Certificate or the Schedule of Benefits.

21. For active orthodontic treatment if started prior to a Member's effective date.

22. For prescription or nonprescription drugs, home care items, vitamins or dietary supplements.

23. For hospitalization and associated costs for rendering services in a hospital.

24. For house or hospital calls for dental services.

25. For any dental or medical services performed by a physician and/or services which benefits are otherwise provided under a health care plan of the employer.

26. Which are Cosmetic in nature as determined by the Company, including, but not limited to bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.

    This exclusion does not apply to Group Contracts and Certificates issued and delivered in Pennsylvania for Cosmetic services required as the result of an accidental injury.

    This exclusion does not apply to Group Contracts and Certificates issued and delivered in New Jersey for Cosmetic services for newly-born children of Members as defined in the definition of Dependent.

    For Group Contracts and Certificates issued and delivered in Maryland services which are Cosmetic in nature, including, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.

27. For broken appointments.

28. Arising from any intentionally self-inflicted injury or contusion when the injury is a consequence of the Member's commission of or attempt to commit a felony or engagement in an illegal occupation or of the Member's being intoxicated or under the influence of illicit narcotics.

    This exclusion does not apply to Group Contracts and Certificates issued and delivered in Maryland and Ohio.

29. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the national guard or in the armed forces of any country or international authority.

LIMITATIONS

The following services, **if listed on the Schedule of Benefits**, will be subject to limitations as set forth below:

1. Bitewing x-rays – one set(s) per six consecutive months through age 13, and one set(s) of bitewing x-rays per 12 consecutive months for age 14 and older.

2. Panoramic or full mouth x-rays – one per three-year period.

3. Prophylaxis – one per six consecutive month period.

4. Routine prophylaxis and periodontal maintenance procedures are limited to no more than any combination of one per six consecutive month period.

5. Sealants – one per tooth per three year(s) through age 15 on permanent first and second molars.

6. Fluoride treatment – one per six consecutive months through age 18.

7. Space maintainers only eligible for Members through age 18 when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop.

8. Restorations, crowns, inlays and onlays – covered only if necessary to treat diseased or fractured teeth.

9. Crowns, bridges, inlays, onlays, buildups, post and cores – one per tooth in a five-year period.

10. Crown lengthening – one per tooth per lifetime.

11. Referral for specialty care is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.

    This limitation does not apply to Group Policies and Certificates issued in Maryland if the service was provided as a result of a standing or non-network referral as described in the Certificate of Coverage.

12. Coverage for referral to a pediatric Specialty Care Dentist ends on a Member's seventh birthday.

13. Pupal therapy – through age five on primary anterior teeth and through age 11 on primary posterior teeth.

14. Root canal treatment – one per tooth per lifetime.

15. Root canal retreatment – one per tooth per lifetime.

16. Periodontal scaling and root planing – one per 24 consecutive month period per area of the mouth.

17. Surgical periodontal procedures – one per 24 consecutive month period per area of the mouth.

18. Full and partial dentures – one per arch in a five-year period.

19. Denture relining, rebasing or adjustments – are included in the denture charges if provided within six months of insertion by the same dentist.

20. Subsequent denture relining or rebasing – limited to one every 36 consecutive months thereafter.

21. Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts up to 1.25cm, frenectomy and crown lengthening.

22. Wisdom teeth (third molars) extracted for Members under age 15 or over age 30 are not eligible for payment in the absence of specific pathology.

23. If for any reason orthodontic services are terminated or coverage under the Company is terminated before completion of the approved orthodontic treatment, the responsibility of the Company will cease with payment through the month of termination.

    For Group Contracts and Certificates issued and delivered in Maryland, services will continue for 60 days after termination if paid monthly, or until the later of 60 days after termination or the end of the quarter in progress if paid quarterly. This extension of orthodontic payment does not apply if coverage was terminated due to failure to pay required Premium, fraud, or if succeeding coverage is provided by another health plan and the cost is less than or equal to the cost of coverage during the extension and there is no interruption of benefits.

24. Orthodontic treatment – not eligible for Members over age 18.

25. Comprehensive orthodontic treatment plan – one per lifetime.

26. In the case of a Dental Emergency involving pain or a condition requiring immediate treatment, the Plan covers necessary diagnostic and therapeutic dental procedures administered by an Out-of-Network Dentist up to the difference between the Out-of-Network Dentist's charge and the Member Copayment up to a maximum of $50 for each emergency visit.

    This limitation does not apply to Group Contracts and Certificates issued and delivered in California and Texas.

27. Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).

28. An Alternate Benefit Provision (ABP) may be applied by the Primary Dental Office if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.