IBX Dental Managed Care

ADA CODE	DESCRIPTION	COPAYMENT
DIAGNOSTIC/PREVENTIVE		
Preventive Reward: Primary subscriber will receive a $20 payment for each family member that receives two cleanings during the plan year from a participating network dentist. Contact your benefit administrator for details.		
	Office visit	$10
D0120	Periodic oral evaluation — Established patient	$0
D0140	Limited oral evaluation — Problem focused	$0
D0145	Oral evaluation for a patient under three years of age	$0
D0150	Comprehensive oral evaluation — New or established patient	$0
D0160	Detailed and extensive oral evaluation — Problem focused	$0
D0170	Re-evaluation — Limited, problem focused	$0
D0180	Comprehensive periodontal evaluation — New or established patient	$35
D0210	Intraoral — Comprehensive 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
D0250	Extraoral — 2D projection radiographic image	$0
D0270-74	Bitewing X-rays — One to four radiographic images	$0
D0277	Vertical bitewings — Seven to eight radiographic images	$0
D0330	Panoramic radiographic image	$25
D0340	2D cephalometric radiographic image	$0
D0350	2D oral/facial photographic images	$0
D0372	Intraoral tomosynthesis — Comprehensive series of radiographic images	$0
D0373	Intraoral tomosynthesis — Bitewing radiographic image	$0
D0374	Intraoral tomosynthesis — Periapical radiographic image	$0
D0387	Intraoral tomosynthesis — Comprehensive series of radiographic images — Image capture only	$0
D0388	Intraoral tomosynthesis — Bitewing radiographic image — Image capture only	$0
D0389	Intraoral tomosynthesis — Periapical radiographic image — Image capture only	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
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
D0701	Panoramic radiographic image — Image capture only	$0
D0702	2-D cephalometric radiographic image — Image capture only	$0

ADA CODE	DESCRIPTION	COPAYMENT
DIAGNOSTIC/PREVENTIVE		
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally — Image capture only	$0
D0705	Extra-oral posterior dental radiographic image — Image capture only	$0
D0706	Intraoral — Occlusal radiographic image — Image capture only	$0
D0707	Intraoral — Periapical radiographic image — Image capture only	$0
D0708	Intraoral — Bitewing radiographic image — Image capture only	$0
D0709	Intraoral — Comprehensive series of radiographic images — Image capture only	$0
D1110	Prophylaxis — Adult	$0
D1110*	Additional cleaning (expecting mothers or diabetics)	$40
D1120	Prophylaxis — Child	$0
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride — Excluding varnish	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320/30	Oral hygiene instructions	$0
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	$0
D1351	Sealant — Per tooth	$15
D1352	Preventive resin restoration moderate/high caries risk — Permanent tooth	$15
D1354	Application of caries arresting medicament — Per tooth	$0
D1355	Caries preventive medicament application — Per tooth	$15
D1510/20	Space maintainer — Fixed/Removable — Unilateral — Per quadrant	$117
D1516/17	Space maintainer — Fixed — Bilateral, maxillary/mandibular	$136
D1526/27	Space maintainer — Removable — Bilateral, maxillary/mandibular	$136
D1551	Recement or rebond bilateral space maintainer — Maxillary	$30
D1552	Recement or rebond bilateral space maintainer — Mandibular	$30
D1553	Recement or rebond unilateral space maintainer — Per quadrant	$30
D1556	Removal of fixed unilateral space maintainer — Per quadrant	$30
D1557	Removal of fixed bilateral space maintainer — Maxillary	$30
D1558	Removal of fixed bilateral space maintainer — Mandibular	$30
D1575	Distal shoe space maintainer — Fixed — Unilateral — Per quadrant	$117
RESTORATIVE (FILLINGS)		
D2140	Amalgam — One surface, primary or permanent	$19
D2150	Amalgam — Two surfaces, primary or permanent	$23
D2160	Amalgam — Three surfaces, primary or permanent	$29
D2161	Amalgam — Four or more surfaces, primary or permanent	$35
D2330	Resin-based composite — One surface, anterior	$46
D2331	Resin-based composite — Two surfaces, anterior	$54
D2332	Resin-based composite — Three surfaces, anterior	$63
D2335	Resin-based composite — Four or more surfaces, anterior	$72
D2390	Resin-based composite crown, anterior	$140
D2391	Resin-based composite — One surface, posterior	$49
D2392	Resin-based composite — Two surfaces, posterior	$57
D2393	Resin-based composite — Three surfaces, posterior	$66
D2394	Resin-based composite — Four or more surfaces, posterior	$75

ADA CODE	DESCRIPTION	COPAYMENT
CROWN AND BRIDGE		
D2510	Inlay — Metallic — One surface	$282
D2520	Inlay — Metallic — Two surfaces	$282
D2530	Inlay — Metallic — Three or more surfaces	$290
D2542	Onlay — Metallic — Two surfaces	$338
D2543	Onlay — Metallic — Three surfaces	$380
D2544	Onlay — Metallic — Four or more surfaces	$380
D2610	Inlay — Porcelain/ceramic — One surface	$302
D2620	Inlay — Porcelain/Ceramic — Two surfaces	$302
D2630	Inlay — Porcelain/Ceramic — Three or more surfaces	$314
D2642	Onlay — Porcelain/Ceramic —Two surfaces	$345
D2643	Onlay — Porcelain/Ceramic — Three surfaces	$355
D2644	Onlay — Porcelain/Ceramic — Four or more surfaces	$355
D2650	Inlay — Resin-based composite — One surface	$272
D2651	Inlay — Resin-based composite — Two surfaces	$272
D2652	Inlay — Resin-based composite — Three or more surfaces	$272
D2662	Onlay — Resin-based composite — Two surfaces	$320
D2663	Onlay — Resin-based composite — Three surfaces	$320
D2664	Onlay — Resin-based composite — Four or more surfaces	$320
D2710	Crown — Resin-based composite (indirect)	$207
D2712	Crown — 3/4 resin-based composite (indirect)	$381
D2720/21/22	Crown — Resin with metal	$342
D2740	Crown — Porcelain/Ceramic	$417
D2750/51/52	Crown — Porcelain fused metal	$380
D2753	Crown — Porcelain fused to titanium and titanium alloys	$380
D2780/81/82	Crown — 3/4 cast with metal	$348
D2783	Crown — 3/4 porcelain/ceramic	$357
D2790/91/92	Crown — Full cast metal	$366
D2794	Crown — Titanium and titanium alloys	$366
D2910/20	Recement inlay, onlay, crown, or partial coverage restoration	$33
D2930	Prefabricated stainless steel crown — Primary tooth	$96
D2931	Prefabrabicated stainless steel crown — Permanent tooth	$105
D2932	Prefabricated resin crown	$105
D2940	Protective restoration	$31
D2950	Core buildup, including any pins	$90
D2951	Pin retention — Per tooth, in addition to restoration	$18
D2952	Post and core in addition to crown	$136
D2954	Prefabricated post and core in addition to crown	$112
D2955	Post removal (not in conjunction with endodontic therapy)	$81
D2980	Crown repair necessitated by restorative material failure	$76
D2981	Inlay repair necessitated by restorative material failure	$76
D2982	Onlay repair necessitated by restorative material failure	$76

ADA CODE	DESCRIPTION	COPAYMENT
ENDODONTICS[1]		
D3110/20	Pulp cap — Direct/Indirect (excluding final restoration)	$21
D3220	Therapeutic pulpotomy (excluding final restoration)	$63
D3221	Pulpal debridement, primary and permanent teeth	$67
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$260
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$334
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$416
D3333	Internal root repair of perforation defects	$75
D3346	Retreat of previous root canal therapy, anterior	$290
D3347	Retreat of previous root canal therapy, premolar	$371
D3348	Retreat of previous root canal therapy, molar	$438
D3351	Apexification/Recalcification — Initial visit	$242
D3352	Apexification/Recalcification — Interim medication replacement	$172
D3353	Apexification/Recalcification — Final visit	$315
D3410	Apicoectomy — Anterior	$238
D3421	Apicoectomy — Premolar (first root)	$268
D3425	Apicoectomy — Molar (first root)	$283
D3426	Apicoectomy (each additional root)	$112
D3430	Retrograde filling — Per root	$89
D3450	Root amputation — Per root	$156
D3471	Surgical repair of root resorption — Anterior	$238
D3472	Surgical repair of root resorption — Premolar	$268
D3473	Surgical repair of root resorption — Molar	$283
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption — Anterior	$238
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption — Premolar	$268
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption — Molar	$283
D3920	Hemisection, not including root canal therapy	$156
D3921	Decoronation or submergence of an erupted tooth	$78
D3950	Canal prep/fitting of preformed dowel or post	$112
PERIODONTICS[1]		
D4210	Gingivectomy or gingivoplasty — Four or more contiguous teeth	$205
D4211	Gingivectomy or gingivoplasty — One to three contiguous teeth	$70
D4240	Gingival flap procedure, including root planing — Four or more contiguous teeth or tooth bounded spaces, per quadrant	$303
D4241	Gingival flap procedure, including root planing — One to three contiguous teeth or tooth bounded spaces, per quadrant	$74
D4260	Osseous surgery — Four or more contiguous teeth	$422
D4261	Osseous surgery — One to three contiguous teeth	$282
D4263	Bone replacement graft — Retained natural tooth — First site in quad	$437
D4264	Bone replacement graft — Retained natural tooth — Each additional site in quad	$340
D4265	Biological materials to aid in soft and osseous tissue regeneration, per site	$238
D4268	Surgical revision procedure, per tooth	$258
D4270	Pedicle soft tissue graft procedure	$378
D4273	Autogenous connective tissue graft procedure, first tooth	$470
D4274	Mesial/Distal wedge procedure, single tooth	$225

ADA CODE	DESCRIPTION	COPAYMENT
PERIOODONTICS[1]		
D4275	Non-autogenous connective tissue graft (including recipient site and donor material), first tooth, implant, or edentulous tooth position in graft	$470
D4277	Free soft tissue graft procedure, first tooth	$358
D4278	Free soft tissue graft procedure, each additional tooth	$55
D4286	Removal of non-resorbable barrier	$70
D4341	Periodontal scaling and root planing — Four or more teeth, per quadrant	$83
D4342	Periodontal scaling and root planing — One to three teeth, per quadrant	$45
D4346	Scaling in presence of generalized moderate or severe gingival inflammation — Full mouth, after oral evaluation	$32
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$64
D4381	Localized delivery of antimicrobial agents	$70
D4910	Periodontal maintenance	$65
PROSTHETICS (DENTURES)		
D5110/20	Complete denture — Maxillary/Mandibular	$578
D5130/40	Immediate denture — Maxillary/Mandibular	$605
D5211/12	Maxillary/Mandibular partial denture — Resin base	$563
D5213/14	Maxillary/Mandibular partial denture — Cast metal framework with resin denture bases (including retentive/clasing materials, rests, and teeth)	$613
D5221/22	Immediate maxillary/mandibular partial denture — Resin base (including retentive/clasing materials, rests, and teeth)	$563
D5223/24	Immediate maxillary/mandibular partial denture — Cast metal framework with resin denture bases (including retentive/clasing materials, rests, and teeth)	$613
D5225/26	Maxillary/Mandibular partial denture — Flexible base	$613
D5227/28	Immediate maxillary/mandibular partial denture — Flexible base (including any clasps, rests, and teeth)	$613
D5282/83	Removable unilateral partial denture — One piece cast metal, maxillary/mandibular	$362
D5284	Removable unilateral partial denture — One piece flexible base (including clasps and teeth) — Per quadrant	$362
D5286	Removable unilateral partial denture — One piece resin (including clasps and teeth) — Per quadrant	$362
D5410/11	Adjust complete denture — Maxillary/Mandibular	$29
D5421/22	Adjust partial denture — Maxillary/Mandibular	$29
D5511/12	Repair broken complete denture base, mandibular/maxillary	$73
D5520	Replace missing or broken teeth — Complete denture	$73
D5611/12	Repair resin partial denture base, mandibular/maxillary	$73
D5621/22	Repair cast partial framework, mandibular/maxillary	$73
D5630/60	Clasp repaired, replaced or added	$95
D5640	Replace broken teeth — Per tooth	$73
D5650	Add tooth to existing partial denture	$73
D5670/71	Replace all teeth and acrylic on cast metal framework	$214
D5710/11	Rebase complete maxillary/mandibular denture	$232
D5720/21	Rebase maxillary/mandibular partial denture	$232
D5725	Rebase hybrid prosthesis	$232
D5730/31	Reline complete maxillary/mandibular denture (chairside)	$130
D5740/41	Reline maxillary/mandibular partial denture (chairside)	$130
D5750/51	Reline complete maxillary/mandibular denture (lab)	$203
D5760/61	Reline maxillary/mandibular partial denture (lab)	$203

ADA CODE	DESCRIPTION	COPAYMENT
PROSTHETICS (DENTURES)		
D5765	Soft liner for complete or partial removable denture — Indirect	$43
D5810/11	Interim complete denture — Maxillary/Mandibular	$318
D5820/21	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary/mandibular	$318
D5850/51	Tissue conditioning — Maxillary/Mandibular	$61
BRIDGE AND PONTICS		
D6000-D6199	All implant services — 15 percent discount (including D0360-D0363 cone beam imaging with implants)	
D6210/11/12	Pontic — Metal	$366
D6240/41/42	Pontic — Porcelain fused metal	$380
D6243	Pontic — Porcelain fused to titanium and titanium alloys	$380
D6245	Pontic — Porcelain/Ceramic	$417
D6250/51/52	Pontic — Resin with metal	$342
D6545	Retainer — Cast metal for resin-bonded fixed prosthesis	$197
D6548	Retainer — Porcelain/Ceramic for resin-bonded fixed prosthesis	$308
D6549	Resin retainer — Resin-bonded fixed prosthesis	$197
D6600	Retainer inlay — Porcelain/Ceramic, two surfaces	$302
D6601	Retainer inlay — Porcelain/Ceramic, three or more surfaces	$314
D6602	Retainer inlay — Cast high noble metal, two surfaces	$282
D6603	Retainer inlay — Cast high noble metal, three or more surfaces	$290
D6604	Retainer inlay — Cast predominantly base metal, two surfaces	$282
D6605	Retainer inlay — Cast predominantly base metal, three or more surfaces	$290
D6606	Retainer inlay — Cast noble metal, two surfaces	$282
D6607	Retainer inlay — Cast noble metal, three or more surfaces	$290
D6608	Retainer onlay — Porcelain/Ceramic, two surfaces	$345
D6609	Retainer onlay — Porcelain/Ceramic, three or more surfaces	$355
D6610	Retainer onlay — Cast high noble metal, two surfaces	$338
D6611	Retainer onlay — Cast high noble metal, three or more surfaces	$380
D6612	Retainer onlay — Cast predominantly base metal, two surfaces	$338
D6613	Retainer onlay — Cast predominantly base metal, three or more surfaces	$380
D6614	Retainer onlay — Cast noble metal, two surfaces	$338
D6615	Retainer onlay — Cast noble metal, three or more surfaces	$380
D6720/21/22	Retainer crown — Resin with metal	$342
D6740	Retainer crown — Porcelain/Ceramic	$417
D6750/51/52	Retainer crown — Porcelain fused metal	$380
D6753	Retainer crown — Porcelain fused to titanium and titanium alloys	$380
D6780	Retainer crown — 3/4 cast high noble metal	$348
D6781	Retainer crown — 3/4 cast predominantly base metal	$348
D6782	Retainer crown — 3/4 cast noble metal	$348
D6783	Retainer crown — 3/4 porcelain/ceramic	$357
D6784	Retainer crown — 3/4 titanium and titanium alloys	$348
D6790/91/92	Crown — Full cast metal	$366
D6794	Retainer crown — Titanium and titanium alloys	$366
D6930	Recement or rebond fixed partial denture	$49
D6980	Fixed partial denture repair	$124

ADA CODE	DESCRIPTION	COPAYMENT
ORAL SURGERY[1]		
D7111	Extraction, coronal remnants — Primary tooth	$27
D7140	Extraction, erupted tooth or exposed root	$50
D7210	Extraction, erupted tooth requiring elevation, etc.	$102
D7220	Removal of impacted tooth — Soft tissue	$123
D7230	Removal of impacted tooth — Partially bony	$145
D7240	Removal of impacted tooth — Completely bony	$181
D7241	Removal of impacted tooth — Completely bony, with unusual surgical complications	$159
D7250	Removal of residual tooth roots	$108
D7251	Coronectomy — Intentional partial tooth removal, impacted teeth only	$159
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$163
D7280	Exposure of an unerupted tooth	$103
D7291	Transseptal fiberotomy/Supra crestal fiberotomy	$39
D7310/20	Alveoloplasty, per quad	$102
D7509	Marsupialization of odontogenic cyst	$288
D7510	Incision and drainage of abscess — Intraoral soft tissue	$70
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$25
D7961	Buccal/Labial frenectomy (frenulectomy)	$179
D7962	Lingual frenectomy (frenulectomy)	$179
D7979	Non-surgical sialolithotomy	$35
ORTHODONTICS[2]		
Invisalign — 15 percent discount		
D8070	Comprehensive orthodontic treatment — Transitional dentition	$3,304
D8080	Comprehensive orthodontic treatment — Adolescent dentition	$3,422
D8090	Comprehensive orthodontic treatment of the adult dentition	$3,658
D8660	Pre-orthodontic treatment exam to monitor	$413
D8670	Periodic orthodontic treatment visit (as part of contract)	$118
D8680	Orthodontic retention	$413
ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative treatment of dental pain — Per visit	$35
D9210/15	Local anesthesia	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9219	Evaluation for deep sedation or general anesthesia	$0
D9222	Deep sedation/General anesthesia — First 15 minutes	$103
D9223	Deep sedation/General anesthesia — Each subsequent 15 minute increment	$103
D9230	Inhalation of nitrous oxide/Analgesia, anxiolysis	$30
D9239	Intravenous moderate sedation/Analgesia — First 15 minutes	$103
D9243	Intravenous moderate sedation/Analgesia — Each subsequent 15 minutes	$103
D9310	Consultation — Diagnostic service provided by dentist or physician other than requesting dentist or physician	$36
D9613	Infiltration of sustained release therapeutic drug, per quadrant	$190
D9910	Application of desensitizing medicament	$18
D9930	Treatment of complications (post-surgical) — Unusual circumstances, by report	$42

ADA CODE	DESCRIPTION	COPAYMENT
ADJUNCTIVE GENERAL SERVICES		
D9944	Occlusal guard — Hard appliance, full arch	$208
D9945	Occlusal guard — Soft appliance, full arch	$208
D9946	Occlusal guard — Hard appliance, partial arch	$208
D9950	Occlusion analysis — Mounted case	$74
D9951	Occlusal adjustment — Limited	$47
D9952	Occlusal adjustment — Complete	$192
D9953	Reline custom sleep apnea appliance (indirect)	$120
D9972-D9975	Internal/External bleaching — 15 percent discount	
D9986	Missed appointment	$50
D9995	Teledentistry — Synchronous; real-time encounter	$0
D9996	Teledentistry — Asynchronous; information stored and forwarded to dentist for subsequent review	$0
D9997	Dental case management — Patients with special health care needs	$50

Managed Dental Care plan options require the selection of a Primary Dental Office (PDO) from the Plan's Managed Dental Care network. The member's PDO provides routine care and arranges or provides most other necessary and appropriate dental services. Except for emergency services, benefits are covered only when provided or properly referred by the member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Certificate of Coverage.

IBX Dental Managed Care Standard Plans — Exclusions and Limitations

For 2-50, 51-99, 100+ sized groups

SERVICE DESCRIPTION	EXCLUSIONS AND LIMITATIONS
DIAGNOSTIC AND PREVENTIVE SERVICES	
Oral evaluations (exams)	Two evaluations are covered per calendar year including a maximum of one comprehensive evaluation
Emergency or problem-focused exam	One problem-focused exam is covered per calendar year
Prophylaxis (cleaning, scaling, and polishing teeth)	Two teeth cleanings (prophylaxis) are covered per calendar year (one additional cleaning is covered during pregnancy and for diabetic patients)
Preventive Rewards	Primary subscriber will receive a $20 payment for each family member that receives two cleanings during the calendar year from a participating network dentist. Contact your benefit administrator for details.
Topical fluoride	One topical fluoride or fluoride varnish is covered per calendar year
Bitewing X-rays	Two bitewing X-rays are covered per calendar year
Periapical X-rays	No limitations
Full mouth or panoramic X-ray	One set of full mouth X-rays or panoramic film is covered every three years
Emergency palliative treatment	No limitations
Sealants	One sealant or preventive resin restoration per tooth is covered per lifetime, up to age 16 (limited to permanent first and second molars)
Teledentistry, synchronous or asynchronous	Teledentistry, synchronous or asynchronous, limited to two per calendar year
Antibiotic injections administered by a dentist	No limitations
Space maintainers	Distal shoe space maintainer — Fixed — Unilateral, limited to once per lifetime
RESTORATIVE SERVICES	
Amalgam and composite fillings (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single-surface restorations)	Replacement of a filling is covered if it is more than two years from the date of original placement
Pin retention of fillings	No limitations
ORAL SURGERY	
Oral surgery, including post-operative care for coronectomy, intentional partial tooth removal	Coronectomy, intentional partial tooth removal, once per tooth per lifetime
Oral surgery, including post-operative care for: removal of teeth, including impacted teeth; extraction of tooth root; alveolectomy, alveoplasty, and frenectomy; excision of periocoronal gingiva, exostosis, or hyper plastic tissue and excision of oral tissue for biopsy; tooth reimplantation and/or stabilization; tooth transplantation; excision of a tumor or cyst and incision and drainage of an abscess or cyst	No limitations
Simple extraction of teeth	No limitations
ENDODONTIC SERVICES	
Endodontic services	Retreatment of root canal is covered if it is more than two years from the original treatment

SERVICE DESCRIPTION	EXCLUSIONS AND LIMITATIONS
PERIODONTIC SERVICES	
Periodontic services, limited to periodontal maintenance	Periodontal maintenance after periodontal surgery is covered twice per calendar year, within 24 months after definitive periodontal therapy
Periodontic services, limited to root scaling and planing	Root planing or scaling is covered once every 24 months, per quadrant
Periodontic services, limited to full mouth debridement	Full mouth debridement is covered once per lifetime
Periodontic services, limited to scaling in presence of generalized moderate or severe gingival inflammation	Scaling in presence of generalized moderate orsevere gingival inflammation — Full mouth, after oral evaluation and in lieu of a covered D1110/D1120, limited to once per two years
Periodontic services, limited to: occlusal adjustment performed with covered surgery; gingivectomy; osseous surgery including flap entry and closure — Surgery perio	No limitations
Other periodontic services	Localized delivery of antimicrobial agents via a controlled release vehichle into disease cravicular tissue per tooth is limited to one benefit per tooth for three teeth per quadrant or a total of 12 teeth for all four quadrants per 12 months. Must have pocket depths of five millimeters or greater. Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site
Periodontic services, limited to occlusal guard (night guard)	No limitations
REPAIRS AND ADJUSTMENTS	
Recementing bridges, inlays, onlays, and crowns	No limitations
Repair of dentures or fixed bridgework	No limitations
ANESTHESIA	
General anesthesia and analgesia, including intravenous sedation	No limitations
Infiltration of sustained release therapeutic drug — Single or multiple sites	No limitations
CROWNS, INLAYS, ONLAYS, AND RESTORATIVE SERVICES	
Crown build-up for non-vital teeth	No limitations
Restoration services	Crown and bridge fees apply to treatment involving five or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25 percent. All fees exclude material upgrades, including the cost of noble and precious metals. An additional fee will be charged by the participating dentist if these materials are used.
PROSTHETICS	
Prosthetic services	Replacement of a bridge, crown, or denture is covered if it is more than seven years from the date of original placement; relining and rebasing of dentures is covered once every 24 months

SERVICE DESCRIPTION	EXCLUSIONS AND LIMITATIONS
IMPLANTS AND RELATED SERVICES	
Implants and related services	Not covered in Managed Care standard plans
Prosthetic services related to implants and related services	Not covered in Managed Care standard plans
ORTHODONTIA	
Orthodontia services	Orthodontia treatment is covered once per lifetime (High Plan only)
OTHER	
Study model (diagnostic cast)	No limitations

ALTERNATE BENEFIT: If: 1) the Plan determines that a less expensive alternate procedure, service, or course of treatment can be performed in place of the proposed treatment to correct a dental condition, and 2) the alternate treatment will produce a professionally satisfactory result, then the maximum the Plan will allow will be the charge for the less expensive treatment.

1. Services which are covered under worker's compensation, employer's liability laws, or the Pennsylvania Motor Vehicle Financial Responsibility Law (Pennsylvania policyholders only).
2. Services which are not necessary for the patient's dental health as determined by the plan.
3. Cosmetic, elective, or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the plan.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism, or developmental malformations where, in the opinion of the plan, such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war (whether declared or undeclared), or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Procedures not listed as covered benefits under this plan.
11. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the plan (with the exception of out-of-area emergency dental services and/or for services provided when a member is referred to an out-of-network specialist).
12. Services related to the treatment of TMD (temporomandibular disorder).
13. Services related to procedures that are of such a degree of complexity as to not be normally performed by a participating general dentist. Above copayments do not apply when performed by a participating plan specialist (with the exception of orthodontics). Participating plan specialists, if available, have entered into an agreement with Dominion National to provide dental services to members at a 25% reduction from their Usual, Customary, and Reasonable (UCR) fees.
14. Elective surgery including, but not limited to, extraction of nonpathologic, asymptomatic impacted teeth including third molars.
15. The Invisalign system and similar specialized braces are not a covered benefit.

Managed Dental Care plan options require the selection of a Primary Dental Office (PDO) from the Plan's Managed Dental Care network. The member's PDO provides routine care and arranges or provides most other necessary and appropriate dental services. Except for emergency services, benefits are covered only when provided or properly referred by the member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Certificate of Coverage.

1 As performed by a participating general dentist. See plan exclusion 13.

2 Phase I treatment (D8010 - D8050) is provided at a 15% reduction from the orthodontist's UCR fees. See exclusion 15 for additional coverage exclusions.

Independence