

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 any questions about Your United Concordia Dental Plan, please call Our Customer Service Department toll free at **1-866-357-3304** or access Our Website at **www.unitedconcordia.com**.

CODE	DESCRIPTION	Member Pays \$	CODE	DESCRIPTION	Member Pays \$
CLINICAL ORAL EVALUATIONS			AMALGAM RESTORATIONS (including polishing)		
D0120	Periodic oral evaluation	5	D2140	Amalgam - one surface, primary or permanent	9
D0140	Limited oral evaluation - problem focused	5	D2150	Amalgam - two surfaces, primary or permanent	12
D0150	Comprehensive oral evaluation	5	D2160	Amalgam - three surfaces, primary or permanent	15
D0170	Re-evaluation - limited, problem focused	5	D2161	Amalgam - four or more surfaces, primary or permanent	17
D0180	Comprehensive periodontal evaluation	5	RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)			D2330	Resin-based composite - one surface, anterior	20
D0210	Intraoral - complete series (including bitewings)	0	D2331	Resin-based composite - two surfaces, anterior	30
D0220	Intraoral - periapical first film	0	D2332	Resin-based composite - three surfaces, anterior	35
D0230	Intraoral - periapical each additional film	0	D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	42
D0240	Intraoral - occlusal film	0	D2391	Resin-based composite - one surface, posterior	45
D0270	Bitewing - single film	0	D2392	Resin-based composite - two surfaces, posterior	75
D0272	Bitewings - two films	0	D2393	Resin-based composite - three surfaces, posterior	88
D0274	Bitewings - four films	0	D2394	Resin-based composite - four or more surfaces, posterior	100
D0277	Vertical bitewings - seven to eight films	0	INLAY/ONLAY RESTORATIONS		
D0330	Panoramic film	0	D2510	Inlay - metallic - one surface	222 ♦
D0340	Cephalometric film	0	D2520	Inlay - metallic - two surfaces	248 ♦
TESTS & EXAMINATIONS			D2530	Inlay - metallic - three or more surfaces	307 ♦
D0460	Pulp vitality tests	0	D2542	Onlay - metallic - two surfaces	282 ♦
D0470	Diagnostic casts	0	D2543	Onlay - metallic - three surfaces	330 ♦
DENTAL PROPHYLAXIS			D2544	Onlay - metallic - four or more surfaces	363 ♦
D1110	Prophylaxis - adult	0	CROWNS - SINGLE RESTORATIONS ONLY		
D1120	Prophylaxis - child	0	D2710	Crown - resin (indirect)	119
TOPICAL FLUORIDE TREATMENT (office procedure)			D2740	Crown - porcelain/ceramic substrate	450
D1203	Topical fluoride, excluding prophylaxis, child	0	D2750	Crown - porcelain fused to high noble metal	420 ♦
D1204	Topical fluoride, excluding prophylaxis, adult	0	D2751	Crown - porcelain fused to predominantly base metal	400
OTHER PREVENTIVE SERVICES			D2752	Crown - porcelain fused to noble metal	410 ♦
D1330	Oral hygiene instructions	0	D2790	Crown - full cast high noble metal	420 ♦
D1351	Sealant - per tooth	0	D2791	Crown - full cast predominantly base metal	400
SPACE MAINTENANCE (passive appliances)					
D1510	Space maintainer - fixed - unilateral	69			
D1515	Space maintainer - fixed - bilateral	108			
D1520	Space maintainer - removable - unilateral	86			
D1525	Space maintainer - removable - bilateral	122			
D1550	Re-cementation of space maintainer	12			

CODE	DESCRIPTION	Member Pays \$	CODE	DESCRIPTION	Member Pays \$
D2792	Crown - full cast noble metal	410 ♦	D3950	Canal preparation and fitting of preformed dowel or post	70
D2799	Provisional crown	97			
OTHER RESTORATIVE SERVICES			SURGICAL SERVICES		
D2910	Recement inlay	23	(including usual postoperative care)		
D2920	Recement crown	25	D4210	Gingivectomy or Gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	207
D2930	Prefabricated stainless steel crown - primary tooth	81	D4211	Gingivectomy or Gingivoplasty - one to three teeth, per quadrant	65
D2931	Prefabricated stainless steel crown - permanent tooth	97	D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	188
D2950	Core buildup, including any pins	75	D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant	75
D2951	Pin retention - per tooth, in addition to restoration	13	D4249	Clinical crown lengthening - hard tissue	259
D2952	Cast post and core in addition to crown	120	D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	360
D2953	Each additional cast post - same tooth	62	D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	144
D2954	Prefabricated post and core in addition to crown	85	D4263	Bone replacement graft - first site in quadrant	130
D2957	Each additional prefabricated post - same tooth	44	D4264	Bone replacement graft - each additional site in quadrant	120
D2970	Temporary crown (fractured tooth)	97	D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	225
PULP CAPPING			NON-SURGICAL PERIODONTAL SERVICES		
D3110	Pulp cap - direct (excluding final restoration)	0	D4341	Periodontal scaling & root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	75
D3120	Pulp cap - indirect (excluding final restoration)	0	D4342	Periodontal scaling & root planing - one to three teeth, per quadrant	19
PULPOTOMY			D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	45
D3220	Therapeutic pulpotomy (excluding final restoration)	52	D4381	Localized delivery of chemotherapeutic agents, per tooth	100
D3221	Pulpal debridement, primary and permanent teeth	26	OTHER PERIODONTAL SERVICES		
ENDODONTIC THERAPY ON PRIMARY TEETH			D4910	Periodontal maintenance	58
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	104	COMPLETE DENTURES		
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	123	(including routine post-delivery care)		
ENDODONTIC THERAPY			D5110	Complete denture - maxillary	375
(including treatment plan, clinical procedures and follow-up care)			D5120	Complete denture - mandibular	375
D3310	Anterior (excluding final restoration)	200	D5130	Immediate denture - maxillary	400
D3320	Bicuspid (excluding final restoration)	250	D5140	Immediate denture - mandibular	400
D3330	Molar (excluding final restoration)	335	PARTIAL DENTURES		
ENDODONTIC RETREATMENT			(including routine post-delivery care)		
D3346	Retreatment of previous root canal therapy - anterior	295	D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	300
D3347	Retreatment of previous root canal therapy - bicuspid	340	D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	300
D3348	Retreatment of previous root canal therapy - molar	428	D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	425
APICOECTOMY/PERIRADICULAR SERVICES			D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	425
D3410	Apicoectomy/Periradicular surgery - anterior	220	D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	195
D3421	Apicoectomy/Periradicular surgery - bicuspid (first root)	240			
D3425	Apicoectomy/Periradicular surgery - molar (first root)	240			
D3426	Apicoectomy/Periradicular surgery (each additional root)	97			
D3430	Retrograde filling - per root	0			
D3450	Root amputation - per root	143			
OTHER ENDODONTIC PROCEDURES					
D3920	Hemisection (including any root removal), not including root canal therapy	130			

CODE	DESCRIPTION	Member Pays \$	CODE	DESCRIPTION	Member Pays \$
ADJUSTMENTS TO DENTURES					
D5410	Adjust complete denture - maxillary	24	D6970	Cast post and core in addition to fixed partial denture retainer	104
D5411	Adjust complete denture - mandibular	24	D6971	Cast post as part of fixed partial denture retainer	76
D5421	Adjust partial denture - maxillary	24	D6972	Prefabricated post and core in addition to fixed partial denture retainer	76
D5422	Adjust partial denture - mandibular	24	D6973	Core build up for retainer, including any pins	82
REPAIRS TO COMPLETE DENTURES			D6976	Each additional cast post - same tooth	38
D5510	Repair broken complete denture base	60	D6977	Each additional prefabricated post - same tooth	38
D5520	Replace missing or broken teeth - complete denture (each tooth)	50	EXTRACTIONS		
REPAIRS TO PARTIAL DENTURES			(includes local anesthesia, suturing, if needed, and routine postoperative care)		
D5610	Repair resin denture base	60	D7111	Coronal remnants - deciduous tooth	14
D5620	Repair cast framework	75	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	35
D5630	Repair or replace broken clasp	75	SURGICAL EXTRACTIONS		
D5640	Replace broken teeth - per tooth	60	(includes local anesthesia, suturing, if needed, and routine postoperative care)		
D5650	Add tooth to existing partial denture	75	D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	60
D5660	Add clasp to existing partial denture	75	D7220	Removal of impacted tooth - soft tissue	78
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	276	D7230	Removal of impacted tooth - partially bony	100
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	276	D7240	Removal of impacted tooth - completely bony	130
DENTURE REBASE PROCEDURES			D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	151
D5710	Rebase complete maxillary denture	155	D7250	Surgical removal of residual tooth roots (cutting procedure)	76
D5711	Rebase complete mandibular denture	155	OTHER SURGICAL PROCEDURES		
D5720	Rebase maxillary partial denture	140	D7280	Surgical access of an unerupted tooth	151
D5721	Rebase mandibular partial denture	140	D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	119
DENTURE RELINE PROCEDURES			ALVEOLOPLASTY		
D5730	Reline complete maxillary denture (chairside)	90	(surgical preparation of ridge for dentures)		
D5731	Reline complete mandibular denture (chairside)	90	D7310	Alveoloplasty in conjunction with extractions - per quadrant	60
D5740	Reline maxillary partial denture (chairside)	80	D7320	Alveoloplasty not in conjunction with extractions - per quadrant	76
D5741	Reline mandibular partial denture (chairside)	80	SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS		
D5750	Reline complete maxillary denture (laboratory)	130	D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	81
D5751	Reline complete mandibular denture (laboratory)	130	OTHER REPAIR PROCEDURES		
D5760	Reline maxillary partial denture (laboratory)	130	D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	108
D5761	Reline mandibular partial denture (laboratory)	130	LIMITED ORTHODONTIC TREATMENT		
OTHER REMOVABLE PROSTHETIC SERVICES			D8010	Limited orthodontic treatment of the primary dentition	550
D5850	Tissue conditioning, maxillary	55	D8020	Limited orthodontic treatment of the transitional dentition	550
D5851	Tissue conditioning, mandibular	55	D8030	Limited orthodontic treatment of the adolescent dentition	550
FIXED PARTIAL DENTURE PONTICS			D8040	Limited orthodontic treatment of the adult dentition	550
D6210	Pontic - cast high noble metal	420 ♦	INTERCEPTIVE ORTHODONTIC TREATMENT		
D6211	Pontic - cast predominantly base metal	400	D8050	Interceptive orthodontic treatment of the primary dentition	775
D6212	Pontic - cast noble metal	410 ♦	D8060	Interceptive orthodontic treatment of the transitional dentition	775
D6240	Pontic - porcelain fused to high noble metal	420 ♦			
D6241	Pontic - porcelain fused to predominantly base metal	400			
D6242	Pontic - porcelain fused to noble metal	410 ♦			
D6245	Pontic - porcelain/ceramic	475			
FIXED PARTIAL DENTURE RETAINERS - CROWNS					
D6740	Crown - porcelain/ceramic	475			
D6750	Crown - porcelain fused to high noble metal	420 ♦			
D6751	Crown - porcelain fused to predominantly base metal	400			
D6752	Crown - porcelain fused to noble metal	410 ♦			
D6790	Crown - full cast high noble metal	420 ♦			
D6791	Crown - full cast predominantly base metal	400			
D6792	Crown - full cast noble metal	410 ♦			
OTHER FIXED PARTIAL DENTURE SERVICES					
D6930	Recement fixed partial denture	42			

CODE	DESCRIPTION	Member Pays \$
COMPREHENSIVE ORTHODONTIC TREATMENT		
(standard 24-month case)		
D8070	Comprehensive orthodontic treatment of the transitional dentition	2,350
D8080	Comprehensive orthodontic treatment of the adolescent dentition	2,350
D8090	Comprehensive orthodontic treatment of the adult dentition	2,350
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
D8210	Removable appliance therapy	250
D8220	Fixed appliance therapy	250
OTHER ORTHODONTIC SERVICES		
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	250
†	Orthodontic records fee	216
UNCLASSIFIED TREATMENT		
D9110	Palliative (emergency) treatment of dental pain, minor procedure	26
PROFESSIONAL CONSULTATION		
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	43
PROFESSIONAL VISITS		
D9440	Office Visit, after regularly scheduled hours	54
MISCELLANEOUS SERVICES		
★	Broken appointment per 15 minutes (without 24-hour notice)	11

CODE	DESCRIPTION	Member Pays \$
FOOTNOTES		
†	Please report under code D8999. Records include all diagnostic procedures, such as cephalometric films, full mouth x-rays, models, and treatment plans.	
★	Please report under code D9999.	
◆	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.	

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 unless listed otherwise in the Member's Schedule of Benefits.
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.