United Concordia dental℠

Concordia Plus
Schedule of Benefits
Plan CA 11

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 Evidence 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.
- In-Network Dentists will charge an additional $125 for the use of precious (high noble) or semi precious (noble) metal.
- 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.

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
D0171	Re-Evaluation - Post-Operative Office Visit	0
D0180	Comprehensive Periodontal Evaluation	0
	RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)	
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	Extra-oral - 2D Projection Radiographic Image Created Using A Stationary Radiation Source, And Detector	0
D0251	Extra-oral Posterior Dental Radiographic Image	0
D0270	Bitewing - Single Radiographic Image	0

ADA Code	ADA Description	Member Pays $
	RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)	
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
D0350	2D Oral/Facial Photographic Image Obtained Intra-Orally Or Extra-Orally	0
D0372	Intraoral Tomosynthesis - Comprehensive Series of Radiographic Images	0
D0373	Intraoral Tomosynthesis – Bitewing Radiographic Image	0
D0374	Splint – Extra-Coronal; Natural Teeth or Prosthetic Crowns	0
	TESTS AND EXAMINATIONS	
D0396	3D Printing of a 3D Dental Surface Scan	0
D0415	Collection Of Microorganisms For Culture And Sensitivity	0
D0416	Viral Culture	0
D0417	Collection And Preparation Of Saliva Sample For Laboratory Diagnostic Testing	10
D0418	Analysis Of Saliva Sample	10
D0422	Collection and Preparation Of Genetic Sample Material For Laboratory Analysis And Report	0
D0423	Genetic Test for Susceptibility To Diseases - Specimen Analysis	0

ADA Code	ADA Description	Member Pays $	
	TESTS AND EXAMINATIONS		
D0425	Caries Susceptibility Tests	0	
D0431	Adjunctive Pre-Diagnostic Test That Aids In Detection Of Mucosal Abnormalities Including Premalignant And Malignant Lesions, Not To Include Cytology Or Biopsy Procedures	0	
D0460	Pulp Vitality Tests	0	
D0470	Diagnostic Casts	0	
	ORAL PATHOLOGY LABORATORY		
D0472	Accession Of Tissue, Gross Examination, Preparation And Transmission Of Written Report	0	
D0473	Accession Of Tissue, Gross And Microscopic Examination, Preparation And Transmission Of Written Report	0	
D0474	Accession Of Tissue, Gross And Microscopic Examination, Including Assessment Of Surgical Margins For Presence Of Disease, Preparation And Transmission Of Written Report	0	
D0502	Other Oral Pathology Procedures, By Report	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	
	DENTAL PROPHYLAXIS		
D1110	Prophylaxis, Adult (1 per 6 months)	0	
	Additional adult prophylaxis (maximum of 1 additional per 6 months)	40	
D1120	Prophylaxis, Child (1 per 6 months)	0	
	Additional child prophylaxis (maximum of 1 additional per 6 months)	30	
	TOPICAL FLUORIDE TREATMENT (office procedure)		
D1206	Topical Application Of Fluoride Varnish	0	
D1208	Topical Application Of Flouride - Excluding Varnish	0	
	OTHER PREVENTIVE SERVICES		
D1301	Immunization Counseling	0	
D1310	Nutritional Counseling For The Control Of Dental Disease	0	
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease	0	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	0	
D1330	Oral Hygiene Instruction	0	
D1351	Sealant - Per Tooth	0	
D1353	Sealant Repair - Per Tooth	0	

ADA Code	ADA Description	Member Pays $	
	OTHER PREVENTIVE SERVICES		
D1354	Application of Caries Arresting Medicament - Per Tooth	15	
D1355	Caries preventive 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	
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	0	
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	0	
D1553	Re-cement or re-bond bilateral space maintainer - per quadrant	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	
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 (Anterior)	0	
D2390	Resin-Based Composite Crown, Anterior	0	
D2391	Resin-Based Composite - One Surface, Posterior	85	
D2392	Resin-Based Composite - Two Surfaces, Posterior	109	
D2393	Resin-Based Composite - Three Surfaces, Posterior	133	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	140	
	INLAY/ONLAY RESTORATIONS		
D2510	Inlay - Metallic - One Surface	20	◆
D2520	Inlay - Metallic - Two Surfaces	20	◆

ADA Code	ADA Description	Member Pays $	
	INLAY/ONLAY RESTORATIONS		
D2530	Inlay - Metallic - Three Or More Surfaces	20	◆
D2542	Onlay - Metallic-Two Surfaces	20	◆
D2543	Onlay - Metallic - Three Surfaces	20	◆
D2544	Onlay - Metallic - Four Or More Surfaces	20	◆
	CROWNS - SINGLE RESTORATIONS ONLY		
D2710	Crown-Resin-Based Composite (Indirect)	20	
D2712	Crown - 3/4 Resin-Based Composite (Indirect)	20	
D2720	Crown, Resin With High Noble Metal	40	◆
D2721	Crown, Resin With Predominantly Base Metal	40	
D2722	Crown, Resin With Noble Metal	40	◆
D2740	Crown, Porcelain/Ceramic	30	
D2750	Crown, Porcelain Fused To High Noble Metal	40	◆
D2751	Crown-Porcelain Fused To Predominantly Base Metal	40	
D2752	Crown, Porcelain Fused To Noble Metal	40	◆
D2753	Crown - porcelain fused to titanium and titanium alloys	40	
D2780	Crown - 3/4 Cast High Noble Metal	40	◆
D2781	Crown - 3/4 Cast Predominantly Base Metal	40	
D2782	Crown - 3/4 Cast Noble Metal	40	◆
D2783	Crown - 3/4 Porcelain/Ceramic	30	
D2790	Crown, Full Cast High Noble Metal	40	◆
D2791	Crown - Full Cast Predominantly Base Metal	40	
D2792	Crown, Full Cast Noble Metal	40	◆
D2794	Crown - titanium and titanium alloys	40	
D2799	Interim Crown - Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression	0	
	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	
D2932	Prefabricated Resin Crown	0	
D2933	Prefabricated Stainless Steel Crown With Resin Window	0	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary 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	

ADA Code	ADA Description	Member Pays $
	OTHER RESTORATIVE SERVICES	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	10
D2954	Prefabricated Post And Core In Addition To Crown	0
D2955	Post Removal	0
D2957	Each Additional Prefabricated Post - Same Tooth	10
D2971	Additional Procedures To Customize a Crown to fit Under an Existing Partial Denture Framework	25
D2980	Crown Repair Necessitated By Restorative Material Failure	0
D2981	Inlay Repair Necessitated By Restorative Material Failure	0
D2982	Onlay Repair Necessitated By Restorative Material Failure	0
D2991	Application of Hydroxyapatite Regeneration Medicament – per tooth	45
	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)	20
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	30
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	40
	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	0
	APEXIFICATION/RECALCIFICATION PROCEDURES	
D3351	Apexification/Recalcification - Initial Visit (Apical Closure / Calcific Repair Of Perforations, Root Resorption, Etc.)	70

ADA Code	ADA Description	Member Pays $
	APEXIFICATION/RECALCIFICATION PROCEDURES	
D3352	Apexification/Recalcification - Interim Medication Replacement (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Pulpal Space Disinfection, Etc.)	45
D3353	Apexification/Recalcification-Final Visit (Includes Completed Root Canal Therapy-Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc.)	45
D3355	Pulpal Regeneration - Initial Visit	70
D3356	Pulpal Regeneration - Interim Medication Replacement	45
D3357	Pulpal Regeneration - Completion Of Treatment	45
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy - Anterior	0
D3421	Apicoectomy - Premolar (First Root)	0
D3425	Apicoectomy - Molar (First Root)	0
D3426	Apicoectomy (Each Additional Root)	0
D3430	Retrograde Filling - Per Root	0
D3450	Root Amputation - Per Root	0
D3471	Surgical repair of root resorption – anterior	0
D3472	Surgical repair of root resorption – premolar	0
D3473	Surgical repair of root resorption – molar	0
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	0
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	0
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	0
	OTHER ENDODONTIC PROCEDURES	
D3910	Surgical Procedure For Isolation Of Tooth With Rubber Dam	0
D3920	Hemisection (Including Any Root Removal) Not Including Root Canal Therapy	0
D3921	Decoronation or submergence of an erupted tooth	0
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	0
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	0
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	0
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	0
D4245	Apically Positioned Flap	0
D4249	Clinical Crown Lengthening-Hard Tissue	0
D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	0
D4261	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	0
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	120
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Additional Site In Quadrant	92
D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed In Conjunction With Surgical Procedures In The Same Anatomical Area)	0
D4286	Removal of Non-Resorbable Barrier	0
	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 Periodontal Evaluation And Diagnosis on a Subsequent Visit	0
D4381	Localized Delivery Of Antimicrobial Agents Via Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth	43
	OTHER PERIODONTAL SERVICES	
D4910	Periodontal Maintenance	0
D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist Or Their Staff)	0
D4921	Gingival Irrigation with a medicinal agent - Per Quadrant	25
	COMPLETE DENTURES (including routine post delivery care)	
D5110	Complete Denture - Maxillary	50
D5120	Complete Denture - Mandibular	50
D5130	Immediate Denture - Maxillary	50
D5140	Immediate Denture - Mandibular	50
	PARTIAL DENTURES (including routine post-delivery care)	
D5211	Maxillary Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests And Teeth)	50

ADA Code	ADA Description	Member Pays $
PARTIAL DENTURES (including routine post-delivery care)		
D5212	Mandibular Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests And Teeth)	50
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	55
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	55
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	50
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	50
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	55
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	55
D5225	Maxillary Partial Denture - Flexible Base (Including Retentive/Clasping materials, Rests And Teeth)	63
D5226	Mandibular Partial Denture - Flexible Base (Including Retentive/Clasping materials, Rests And Teeth)	63
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	50
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	50
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	25
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	25
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests and teeth) - per quadrant	25
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests and teeth) - per quadrant	25
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
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)	36
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	36
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
D5725	Rebase hybrid prosthesis	0
DENTURE RELINE PROCEDURES		
D5730	Reline Complete Maxillary Denture (direct)	0
D5731	Reline Complete Mandibular Denture (direct)	0
D5740	Reline Maxillary Partial Denture (direct)	0
D5741	Reline Mandibular Partial Denture (direct)	0
D5750	Reline Complete Maxillary Denture (indirect)	15
D5751	Reline Complete Mandibular Denture (indirect)	15
D5760	Reline Maxillary Partial Denture (indirect)	15
D5761	Reline Mandibular Partial Denture (indirect)	15
D5765	Soft liner for complete or partial removable denture – indirect	0
D5810	Interim Complete Denture (Maxillary)	50
D5811	Interim Complete Denture (Mandibular)	50
D5820	Interim Partial Denture (including retentive/clasping materials, rests and teeth), maxillary	25
D5821	Interim Partial Denture (including retentive/clasping materials, rests and teeth), mandibular	25
OTHER REMOVABLE PROSTHETIC SERVICES		
D5850	Tissue Conditioning, Maxillary	0
D5851	Tissue Conditioning, Mandibular	0

ADA Code	ADA Description	Member Pays $	
	OTHER REMOVABLE PROSTHETIC SERVICES		
D5863	Overdenture - Complete Maxillary	50	
D5864	Overdenture - Partial Maxillary	55	
D5865	Overdenture - Complete Mandibular	50	
D5866	Overdenture - Partial Mandibular	55	
	FIXED PARTIAL DENTURE PONTICS		
D6205	Pontic - Indirect Resin Based Composite	40	
D6210	Pontic-Cast High Noble Metal	40	◆
D6211	Pontic-Cast Predominatly Base Metal	40	
D6212	Pontic-Cast Noble Metal	40	◆
D6214	Pontic - titanium and titanium alloys	40	
D6240	Pontic-Porcelain Fused To High Noble Metal	40	◆
D6241	Pontic-Porcelain Fused To Predominantly Base Metal	40	
D6242	Pontic-Porcelain Fused To Noble Metal	40	◆
D6243	Pontic - porcelain fused to titanium and titanium alloys	40	
D6245	Pontic - Procelain/Ceramic	40	
D6250	Pontic, Resin With High Noble Metal	40	◆
D6251	Pontic, Resin With Predominantly Base Metal	40	
D6252	Pontic, Resin With Noble Metal	40	◆
	FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS		
D6545	Retainer-Cast Metal For Resin Bonded Fixed Prosthesis	40	
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	60	
D6549	Resin Retainer - For Resin Bonded Fixed Prosthesis	40	
D6602	Retainer Inlay - Cast High Noble Metal, Two Surfaces	20	◆
D6603	Retainer Inlay - Cast High Noble Metal, Three Or More Surfaces	20	◆
D6604	Retainer Inlay - Cast Predominantly Base Metal, Two Surfaces	20	
D6605	Retainer Inlay - Cast Predominantly Base Metal, Three Or More Surfaces	20	
D6606	Retainer Inlay - Cast Noble Metal, Two Surfaces	20	◆
D6607	Retainer Inlay - Cast Noble Metal, Three Or More Surfaces	20	◆
D6610	Retainer Onlay - Cast High Noble Metal, Two Surfaces	20	◆
D6611	Retainer Onlay - Cast High Noble Metal, Three Or More Surfaces	20	◆
D6612	Retainer Onlay - Cast Predominantly Base Metal, Two Surfaces	20	
D6613	Retainer Onlay - Cast Predominantly Base Metal, Three Or More Surfaces	20	
D6614	Retainer Onlay - Cast Noble Metal, Two Surfaces	20	◆
D6615	Retainer Onlay - Cast Noble Metal, Three Or More Surfaces	20	◆
D6624	Retainer Inlay - Titanium	20	
D6634	Retainer Onlay - Titanium	20	
	FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6710	Retainer Crown - Indirect Resin Based Composite	40	

ADA Code	ADA Description	Member Pays $	
	FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6720	Retainer Crown, Resin With High Noble Metal	40	◆
D6721	Retainer Crown, Resin With Predominantly Base Metal	40	
D6722	Retainer Crown, Resin With Noble Metal	40	◆
D6740	Retainer Crown - Porcelain/Ceramic	40	
D6750	Retainer Crown, Porcelain Fused To High Noble Metal	40	◆
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	40	
D6752	Retainer Crown, Porcelain Fused To Noble Metal	40	◆
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	40	
D6780	Retainer Crown, 3/4 Cast High Noble Metal	40	◆
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	40	
D6782	Retainer Crown - 3/4 Cast Noble Metal	40	◆
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	40	
D6784	Retainer crown 3/4 - titanium and titanium alloys	40	
D6790	Retainer Crown, Full Cast High Noble Metal	40	◆
D6791	Retainer Crown, Full Cast Predominantly Base Metal	40	
D6792	Retainer Crown, Full Cast Noble Metal	40	◆
D6794	Retainer crown - titanium and titanium alloys	40	
	OTHER FIXED PARTIAL DENTURE SERVICES		
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	0	
D6940	Stress Breaker	40	
D6950	Precision Attachment	60	
D6980	Fixed Partial Denture Repair Necessitated By Restorative Material Failure	0	
	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	0	
D7220	Removal Of Impacted Tooth - Soft Tissue	0	
D7230	Removal Of Impacted Tooth - Partially Bony	0	
D7240	Removal Of Impacted Tooth - Completely Bony	0	
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	0	

ADA Code	ADA Description	Member Pays $
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	0
D7251	Coronectomy-Intentional Partial Tooth Removal, impacted teeth only	0
OTHER SURGICAL PROCEDURES		
D7280	Exposure Of An Unerupted Tooth	0
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	0
D7284	Excisional biopsy of minor salivary glands	245
D7285	Incisional Biopsy Of Oral Tissue-Hard (Bone, Tooth)	0
D7286	Incisional Biopsy Of Oral Tissue-Soft	0
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	0
D7311	Alveoloplasty In Conjuction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quandrant	0
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	0
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	0
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS		
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	0
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	0
EXCISION OF BONE TISSUE		
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0
D7472	Removal Of Torus Palatinus	0
D7473	Removal Of Torus Mandibularis	0
D7485	Reduction Of Osseous Tuberosity	0
SURGICAL INCISION		
D7509	Marsupialization of Odontogenic Cyst	245
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	0
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	0
REPAIR OF TRAUMATIC WOUNDS		
D7910	Suture Of Recent Small Wounds Up To 5 Cm	0
OTHER REPAIR PROCEDURES		
D7961	Buccal / labial frenectomy (frenulectomy)	0
D7962	Lingual frenectomy (frenulectomy)	0
D7963	Frenuloplasty	0
D7970	Excision Of Hyperplastic Tissue - Per Arch	0
D7971	Excision Pericoronal Gingival	0
LIMITED ORTHODONTIC TREATMENT		
D8010	Limited Orthodontic Treatment Of Primary Dentition	1500
D8020	Limited Orthodontic Treatment Of Transitional Dentition	1500
D8030	Limited Orthodontic Treatment Of Adolescent Dentition	1500
D8040	Limited Orthodontic Treatment Of The Adult Dentition	1500
COMPREHENSIVE ORTHODONTIC TREATMENT		
D8070	Comprehensive Orthodontic Treatment Of Transitional Dentition	1500
D8080	Comprehensive Orthodontic Treatment Of Adolescent Dentition	1500
D8090	Comprehensive Orthodontic Treatment Of Adult Dentition	2000
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
D8210	Removable Appliance Therapy For Control Of Harmful Habits	750
D8220	Fixed Appliance Therapy For Control Of Harmful Habits	750
OTHER ORTHODONTIC SERVICES		
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	15
D8670	Periodic Orthodontic Treatment Visit	0
D8680	Orthodontic Retention (Removal Of Appliances, Construction And Placement Of Retainer(S)	240
✞	Orthodontic Records Fee	265
UNCLASSIFIED TREATMENT		
D9110	Palliative Treatment Of Dental Pain - per visit	0
D9120	Fixed Partial Denture Sectioning	0
ANESTHESIA		
D9210	Local Anesthesia (Not In Conjunction With Operative Or Surgical Procedures)	0
D9211	Regional Block Anesthesia	0
D9212	Trigeminal Division Block Anesthesia	0
D9215	Local Anesthesia In Conjunction With Operative Or Surgical Procedures	0
D9219	Evaluation For Moderate Sedation, Deep Sedation Or General Anesthesia	0
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	80
D9223	Deep Sedation/General Anesthesia - Each Subsequent 15 Mintue Increment	80
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	85

ADA Code	ADA Description	Member Pays $
	ANESTHESIA	
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute Increment	85
	PROFESSIONAL CONSULTATION	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician Other Than Requesting Dentist Or Physician	0
D9311	Consultation With A Medical Health Care Professional	0
	PROFESSIONAL VISITS	
D9430	Office Visit For Observation (During Regularly Scheduled Hours) - No Other Services Performed	0
D9440	Office Visit After Regularly Scheduled Hours	40
D9450	Case Presentation, Susbsequent to Detailed And Extensive Treatment Planning	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
D9942	Repair And/Or Reline Of Occlusal Guard	25
D9943	Occlusal Guard Adjustment	24
D9944	Occlusal Guard - hard appliance, full arch	95
D9946	Occlusal Guard - hard appliance, partial arch	95
D9951	Occlusal Adjustment (Limited)	0
D9952	Occlusal Adjustment (Complete)	0
D9986	Missed Appointment	20
D9987	Cancelled appointment	20
D9990	Certified translation or sign-language services - per visit	0
D9991	Dental Case Management - Addressing Appointment Compliance Barriers	0
D9992	Dental Case Management - Care Coordination	0
D9993	Dental Case Management - Motivational Interviewing	0
D9994	Dental Case Management - Patient Education To Improve Oral Health Literacy	0
D9997	Dental care management - patients with special health care needs	0
	BLEACHING	
D9975	External Bleaching For Home Application, Per Arch, Includes Materials And Fabrication Of Custom Trays	125
	FOOTNOTES	

ADA Code	ADA Description	Member Pays $
	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.	
✞	Please Report Under Code D8999 "Unspecified Orthodontic Procedure, By Report." Records Include All Diagnostic Procedures, Such As Cephalometric Films, Full Mouth X-Rays, Models, And Treatment Plans.	

SCHEDULE OF EXCLUSIONS & LIMITATIONS

EXCLUSIONS:

Except as specifically provided in this 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 outside of the office in which the Member is enrolled and which are not pre-authorized by the Company (including specialty care services).
3. Which in the opinion of the treating dentist, or the Company, are not clinically necessary, or do not have a reasonable, favorable prognosis.
4. That are necessary due to lack of cooperation with the treating dentist, or failure to comply with a professionally prescribed Treatment Plan.
5. Started or incurred prior to the Member's eligibility under the Company or 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. That do not meet accepted standards of dental treatment, which are Experimental or Investigative in nature or are considered enhancements to standard dental treatment as determined by the Company.
8. For hospitalization and associated costs for rendering services in a hospital.
9. Determined by the Company to be the responsibility of Worker's Compensation or employer's liability or health care plan, or payable under any Federal Government or state program, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy, or for services for which benefits are payable under any other insurance.
10. For prescription or non-prescription drugs, home care items, vitamins or dietary supplements.
11. Which are principally Cosmetic in nature, including, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures as determined by the Company.
12. For diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome 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.
13. For services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion, including, but not limited to, full mouth rehabilitation, splinting, appliances or any other method.
14. That restore tooth structure lost due to attrition, erosion or abrasion.
15. For replacement of lost, missing, stolen or damaged prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device.
16. 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 twenty-four (24) months.
17. For implants, surgical insertion and/or removal of, and any appliances and/or prosthetics attached to implants.
18. Required because of, or in connection with, acts of war, declared or undeclared.
19. For elective procedures, including, but not limited to, prophylactic extractions of third molars.

LIMITATIONS

The following services will be subject to Limitations as set forth below:

1. Referral to a Specialty Care Dentist is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.
2. Coverage for referral to a pediatric Specialty Care Dentist ends on a Member's 7th birthday. However, exceptions for physical or mental handicaps or medically compromised children, when confirmed by a physician, may be considered on an individual basis with prior approval from the Company.
3. Member must remain in the Plan during the period of time they are undergoing orthodontic treatment. Any early termination can result in additional charges for all unfinished work. This limitation only applies to subscriber termination, not group termination.
4. Sealants – one (1) per tooth per three (3) year period through age ten (10) on permanent first molars and through age fifteen (15) on permanent second molars.
5. In the case a Dental Emergency involving pain or a condition requiring immediate treatment occurring more than fifty (50) miles from the Member's home, the Plan covers necessary diagnostic and therapeutic dental procedures administered by a dentist up to a maximum of $100 for each emergency visit.
6. Periodontal maintenance following active periodontal therapy - two (2) per twelve (12) consecutive months in combination with routine prophylaxis.
7. Periodontal scaling and root planing - one (1) per twenty-four (24) consecutive month period per area of the mouth.
8. Surgical periodontal procedures - one (1) per thirty-six (36) consecutive month period per area of the mouth.
9. Root canal retreatment - one (1) per tooth per lifetime.
10. Panoramic or full mouth x-rays - one (1) every three (3) years.
11. One (1) set of bitewing x-rays per six (6) consecutive months.
12. Prophylaxis - one (1) per six (6) consecutive months, unless otherwise specified in the Schedule of Benefits.
13. Fluoride treatment - one (1) per six (6) consecutive months through age eighteen (18).
14. Crown lengthening - one (1) per tooth per lifetime.
15. Denture relining or rebasing - integral if provided within six (6) months of insertion by the same dentist. This limitation does not apply to immediate dentures.
16. Subsequent denture relining or rebasing - limited to one (1) every thirty-six (36) consecutive months thereafter.
17. 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).

Governing Administrative Guidelines

Alternative Treatment

Occasionally, the Panel Dental Office and/or the member may consider alternative treatment plans. In those instances where the member agrees to an alternative treatment plan rather than the benefit provided by United Concordia, the cost for such treatment will be based upon the following formula:

Provider's Usual Fee of the alternate treatment	***less***	Provider's Usual Fee of the entitled benefit	***plus***	Member's Copayment for the entitled benefit	=	**FEE CHARGED TO MEMBER**

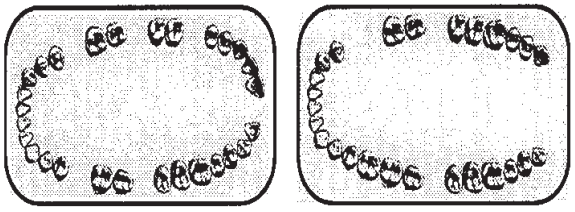
Fixed Prosthetics (Bridges)
Services must be diagnosed and prescribed by the participating provider to be eligible for coverage. The member is eligible for fixed bridge restoration when:

- there is a posterior one-sided space involving one or two adjacent teeth, and front and back anchor teeth;
- the bridge will replace incisor teeth missing in the upper or lower anterior segments defined as cuspid to cuspid (#6-11 or #22-27);
- anchor teeth and occlusion are clinically healthy, resulting in a favorable prognosis.

The Plan does not cover a fixed bridge when:

- there are missing teeth on both sides of the mouth in the same arch (bridges currently in place are not considered missing teeth unless unserviceable). *
- anterior (front) and posterior (back) spaces (missing teeth) are present in the same arch. In this case, a partial denture is the covered benefit.*
- replacing a serviceable partial denture or fixed bridge;
- the bridge is used to realign misaligned teeth, including diastemas (spaces between teeth);
- the member is under the age of 16 and having permanent teeth replaced;
- one or more anchor teeth is an implant.

*Note: The term "missing teeth" does not include third molars for the purpose of this guideline. In addition, missing teeth do not apply to this guideline if the resultant space is closed to less than 1/2 of the width of a bicuspid.



Bridge Ineligibility **Bridge Eligibility**

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: United Concordia Dental Plans of California, Inc.
Policy Type: DHMO
Effective Date: Beginning on or after 10/01/1998

Name of Product: Concordia Plus CA 11
Plan Phone #: 866-357-3304
Plan Website: www.unitedconcordia.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE INSURER WEBSITE www.unitedconcordia.com OR CALL 866-357-3304.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	Not Applicable
Orthodontia	None	Not Applicable

- **There is no deductible**
- A **Deductible** is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.

- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	None	Not Applicable
Lifetime or Annual Maximum for Orthodontia	None	Not Applicable

- **Annual maximum** is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **There is no waiting period**.

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions (For a comprehensive list, see the Schedule of Exclusions & Limitations attached to Evidence of Coverage
Oral Exam	Preventive & Diagnostic	$0	Not covered	Not subject to any frequency limitation
Bitewing X-ray	Preventive & Diagnostic	$0	Not covered	One (1) set of bitewing x-rays per six (6) consecutive months.
Cleaning	Preventive & Diagnostic	$0	Not covered	One (1) per six (6) consecutive months, unless otherwise specified in the Schedule of Benefits
Filling	Basic	$0	Not covered	Not subject to any frequency limitation
Extraction, Erupted Tooth or Exposed Root	Basic	$0	Not covered	Limited to Dentally Necessary Procedures
Root Canal	Basic	$40	Not covered	One (1) per tooth per lifetime
Scaling and Root Planing	Basic	$0	Not covered	One (1) per twenty-four (24) consecutive month period per area of the mouth
Ceramic Crown	Major	$30	Not covered	Not subject to any frequency limitation
Removable Partial Denture	Major	$25	Not covered	Not subject to any frequency limitation
Extraction, Erupted Tooth with Bone Removal	Major	$0	Not covered	Limited to Medically Necessary Procedures
Orthodontia	Orthodontia	$2,000	Not covered	Lifetime maximum per member and subject to an age limitation

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (full-mouth x-rays) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: $**400** Out-of-Network:$**550**	Total Cost of Care	In-network: $**150** Out-of-Network:$**200**	Total Cost of Care	In-network: $**1,300** Out-of Network:$**1,750**
Deductible	In-network: $0 Out-of-Network: Not Applicable	Deductible	In-network: $0 Out-of-Network: Not Applicable	Deductible	In-network: $0 Out-of-Network: Not Applicable
Annual Maximum (Plan Will Pay)	In-network: None Out-of-Network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: None Out-of-Network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: None Out-of-Network: Not Applicable
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-Network:	Patient Cost (copayment or coinsurance)	In-network: $85 Out-of-Network:	Patient Cost (copayment or coinsurance)	In-network: $30 Out-of-Network:

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
	Not Covered		Not Covered		Not Covered
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-Network:** $500	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $85 **Out-of-Network:** $200	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $30 **Out-of-Network:** $1,750
Summary of what is not covered or subject to a limitation:	Oral Exams - not subject to any frequency limitation Bitewing x-rays - One (1) set of bitewing x-rays per six (6) consecutive months. Cleaning – one (1) per six (6) consecutive months, unless otherwise specified on the Scheudle of Benefits. See Schedule of Exclusions & Limitations	Summary of what is not covered or subject to a limitation:	Not subject to any frequency limitation See Schedule of Exclusions & Limitations attached to Evidence of Coverage for comprehensive list of exclusions and limitations.	Summary of what is not covered or subject to a limitation:	Not subject to any frequency limitation See Schedule of Exclusions & Limitations attached to Evidence of Coverage for comprehensive list of exclusions and limitations.

Dana’s Visit	Dana’s Cost	Sam’s Visit	Sam’s Cost	Maria’s Visit	Maria’s Cost
	attached to Evidence of Coverage for comprehensive list of exclusions and limitations.				