Schedule B Indemnity plan
People First Plan Code #4084

Schedule of benefits:

Calendar year deductible	
Waived for Type I – preventive dental services	$50 individual $150 family (3 per family)
Calendar year maximum	
Type I, II, III	$1,000 per covered person
Waiting period	
Type I, II, III	None

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
TYPE I - PREVENTIVE DENTAL SERVICES		
D0120	Periodic oral examination[1]	$11.70
D0140	Limited oral evaluation - (problem focused)[1]	$15.30
D0150	Comprehensive oral evaluation - new or established patient[1]	$15.30
D0180	Comprehensive periodontal evaluation - new or established patient[1]	$15.30
[1] *Covered twice per 12 consecutive months*		
D0210	Intraoral - complete series, inc. bitewings (Covered once per 3 years)	$30.60
D0220	Intraoral - periapical - first film	$6.30
D0230	Intraoral - periapical - each additional film.	$6.30
D0240	Intraoral - occlusal film	$8.10
D0250	Extraoral - first film.	$10.80
D0260	Extraoral - each additional	$9.00
D0270	Bitewings - single film (Covered twice per 12 consecutive months)	$9.90
D0272	Bitewings - two films (Covered twice per 12 consecutive months)	$12.60
D0274	Bitewings - four films (Covered twice per 12 consecutive months)	$16.20
D0290	Posterior - anterior or lateral skull and facial bone survey film.	$21.60
D0330	Panoramic film (Covered once per 3 year period).	$23.40
D0415	Bacteriologic studies for determination of pathologic agents	$18.00
D1110	Prophylaxis - adult (Covered twice per 12 consecutive months)	$18.90
D1120	Prophylaxis - child (Covered twice per 12 consecutive months)	$18.00
D1201	Topical application of fluoride (prophylaxis included) - child (Covered twice per 12 consecutive months for a dependent child under 16).	$21.60
D1203	Topical application of fluoride (prophylaxis not included) - child (Covered twice per 12 consecutive months for a dependent child under 16).	$15.30
D1351	Sealant - per tooth (Covered once per 12 consecutive months for a dependent child under age 13)	$6.30
D1510	Space maintainer - fixed - unilateral	$80.10
D1515	Space maintainer - fixed - bilateral.	$108.00
D1520	Space maintainer - removable - unilateral	$100.80
D1525	Space maintainer - removable - bilateral	$109.80
D1550	Recementation of space maintainer	$13.50
D7285	Biopsy of oral tissue - hard	$45.00
D7286	Biopsy of oral tissue - soft.	$30.60
D9110	Palliative treatment (Covered as seperate procedure if no other service, except x-rays, is rendered during the visit)	$14.40
TYPE II - BASIC DENTAL SERVICES		
D2140	Amalgam - one surface, primary or permanent[2]	$11.70
D2150	Amalgam - two surfaces, primary or permanent[2]	$18.00
D2160	Amalgam - three surfaces, primary or permanent[2]	$22.50
D2161	Amalgam - four or more surfaces, primary or permanent[2]	$28.80
[2] *Multiple restorations on one surface will be covered as a single filling*		

Insured or administered by HumanaDental Insurance Company, CompBenefits Company, or CompBenefits Insurance Company.

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ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D2330	Resin-based composite- one surface, anterior[3]	$15.30
D2331	Resin-based composite - two surfaces, anterior[3]	$22.50
D2332	Resin-based composite - three surfaces, anterior[3]	$30.60
D2335	Resin-based composite - four or more surfaces or involving incisal angle[3]	$28.80
D2391	Resin-based composite - one surface, posterior[3]	$11.70
D2392	Resin-based composite - two surfaces, posterior[3]	$18.80
D2393	Resin-based composite - three surfaces, posterior[3]	$22.50
D2394	Resin-based composite - four or more surfaces, posterior[3]	$22.50

[3] *Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be deemed single surface restorations.*

D2910	Recement inlay	$11.70
D2920	Recement crown	$11.70
D2940	Sedative filling (Covered as seperate procedure if no other service, except x-rays, rendered during the visit)	$12.60
D2950	Core buildup, including any pins	$36.00
D2951	Pin retention - per tooth - in addition to restoration	$17.10
D3220	Therapeutic pulpotomy, excluding final restoration	$20.70
D3310	Root canal therapy - anterior, excluding final restoration	$162.00
D3320	Root canal therapy - bicuspid, excluding final restoration	$198.00
D3330	Root canal therapy - molar, excluding final restoration	$243.00
D3351	Apexification/recalcification - initial visit	$45.90
D3352	Apexification/recalcification - interim medication	$45.90
D3353	Apexification/recalcification - final visit	$45.90
D3410	Apicoectomy/periradicular surgery - anterior	$71.10
D3421	Apicoectomy/periradicular surgery - bicuspid	$71.10
D3425	Apicoectomy/periradicular surgery - molar	$71.10
D3430	Retrograde filling - per tooth	$26.10
D3450	Root amputation - per root	$38.70
D3920	Hemisection (including root removal), not including root canal therapy	$38.70
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth, per quadrant[4]	$51.30
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant[4]	$13.50
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth, per quadrant[4]	$57.60
D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant[4]	$57.60

[4] *Only one of these procedures is covered per area of the mouth.*

D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth, per quadrant	$95.40
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	$95.40
D4270	Pedicle soft tissue graft procedure	$57.60
D4271	Free soft tissue graft procedure (including donor site surgery)	$63.90
D4320	Provisional splinting - intracoronal	$18.00
D4321	Provisional splinting - extracoronal	$18.00
D4341	Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth, per quadrant[5]	$14.40
D4342	Periodontal scaling and root planing, one to three teeth, per quadrant[5]	$14.40
D4355	Full mouth debridement to enable comprehensive eval. and diagnosis[5]	$30.60
D4910	Periodontal maintenance[5]	$19.80

[5] *Covered twice per area of the mouth per 12 consecutive months*

D5510	Repair broken complete denture base[6]	$26.10

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ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D5520	Replace missing or broken teeth - complete denture[6]	$26.10
D5610	Repair resin denture base[6]	$26.10
D5620	Repair cast framework[6]	$26.10
D5630	Repair or replace broken clasp[6]	$30.60
D5640	Replace broken teeth - per tooth[6]	$18.90
D5650	Add tooth to existing partial denture[6]	$36.00
D5660	Add clasp to existing partial denture[6]	$38.70
D5710	Rebase complete maxillary denture[6]	$76.50
D5711	Rebase complete mandibular denture[6]	$76.50
D5720	Rebase maxillary partial denture[6]	$76.50
D5721	Rebase mandibular partial denture[6]	$76.50
D6930	Recement fixed partial denture.	$16.20
D7111	Coronal remnants, deciduous tooth	$14.40
D7140	Extraction, erupted tooth or exposed root (elev. and/or forceps removal)	$14.40
D7210	Surgical removal of erupted tooth	$26.10
D7220	Removal of impacted tooth - soft tissue	$36.00
D7230	Removal of impacted tooth - partially bony	$45.90
D7240	Removal of impacted tooth - completely bony	$61.20
D7250	Surgical removal of residual tooth roots	$28.80
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$47.70
D7272	Tooth transplantation	$51.30
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$21.60
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$21.60
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$25.20
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$25.20
D7340	Vestibuloplasty - ridge extension (second epithelialization)	$38.70
D7350	Vestibuloplasty - ridge extension (incl. tissue procedures)	$76.50
D7510	Incision and drainage of abscess - intraoral soft tissue.	$22.50
D7520	Incision and drainage of abscess - extraoral soft tissue.	$34.20
D7960	Frenulectomy - separate procedure	$33.30
D7970	Excision of hyperplastic tissue - per arch	$38.70
D9220	Deep sedation/general anesthesia - first 30 minutes[7]	$30.60
D9610	Therapeutic drug injection	$11.70
D9951	Occlusal adjustment - limited[8]	$14.40
D9952	Occlusal adjustment - Complete[8]	$36.90

[6] *Covered only if repairs/adjustments more than 1 year after the initial insertion*

[7] *Covered as a separate procedure only when required for covered complex oral surgical procedures as determined by the company.*

[8] *Covered only when performed with periodontal surgery or nonsurgical TMJ dysfunction treatment.*

TYPE III - MAJOR DENTAL SERVICES

D0470	Diagnostic casts	$15.30
D2510	Inlay - metallic - one surface	$57.60
D2520	Inlay - metallic - two surfaces	$79.20
D2530	Inlay - metallic - three or more surfaces	$85.50
D2610	Inlay - porcelain/ceramic - one surface	$26.10
D2620	Inlay - porcelain/ceramic - two surfaces	$52.20
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$78.30
D2710	Crown resin (laboratory) (Single restoration only)	$51.30
D2720	Crown - resin high noble metal (Single restoration only)	$98.10
D2721	Crown - resin predominantly base metal (Single restoration only)	$85.50
D2722	Crown - resin with noble metal (Single restoration only)	$89.10
D2740	Crown - porcelain/ceramic substrate (Single restoration only)	$95.40
D2750	Crown - porcelain fused to high noble metal (Single restoration only)	$180.00
D2751	Crown - porcelain fused to predominantly base metal (Single restoration only).	$91.80

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ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D2752	Crown - porcelain fused to noble metal (Single restoration only)	$95.40
D2790	Crown - full cast high noble metal (Single restoration only)	$175.50
D2791	Crown - full cast predominantly base metal (Single restoration only)	$82.80
D2792	Crown - full cast noble metal (Single restoration only)	$89.10
D2930	Prefabricated stainless steel crown - primary tooth (Single restoration only)	$21.60
D2931	Prefabricated stainless steel crown - permanent (Single restoration only)	$21.60
D2952	Cast post and core in addition to crown (Single restoration only)	$36.00
D2954	Prefabricated post and core in addition to crown (Single restoration only)	$26.10
D5110	Complete upper denture	$129.60
D5120	Complete lower denture	$129.60
D5130	Immediate upper denture	$135.90
D5140	Immediate lower denture	$135.90
D5211	Upper partial denture - resin base	$79.20
D5212	Lower partial denture - resin base	$79.20
D5213	Upper partial denture - cast metal base with resin saddles	$145.80
D5214	Lower partial denture - cast metal base with resin saddles	$134.10
D5281	Removable unilateral partial denture - one piece cast metal	$28.80
D5410	Adjust complete denture - upper[9]	$8.10
D5411	Adjust complete denture - lower[9]	$8.10
D5421	Adjust partial denture - upper[9]	$8.10
D5422	Adjust partial denture - lower[9]	$8.10
D5730	Reline complete upper denture (chairside)[10]	$32.40

[9] *Covered only once per 12 consecutive months and only if done more than one year after the initial insertion of the denture)*

D5731	Reline complete lower denture (chairside) [10]	$32.40
D5740	Reline upper partial denture (chairside)[10]	$26.10
D5741	Reline lower partial denture (chairside)[10]	$26.10
D5750	Reline complete upper denture (laboratory) [10]	$47.70
D5751	Reline complete lower denture (laboratory) [10]	$47.70
D5760	Reline upper partial denture (laboratory) [10]	$41.40
D5761	Reline lower partial denture (laboratory)[10]	$41.40

[10] *Covered only if relining is done more than 1 year after the initial insertion and then not more than once per 2 year period*

D6210	Pontic - cast high noble metal	$175.50
D6211	Pontic - cast predominantly base metal	$82.80
D6212	Pontic - cast noble metal	$89.10
D6240	Pontic - porcelain fused to high noble metal	$180.00
D6241	Pontic - porcelain fused to predominately base metal	$91.80
D6242	Pontic - porcelain fused to noble metal	$95.40
D6250	Pontic - resin with high noble metal	$98.10
D6251	Pontic - resin with predominately base metal	$85.50
D6252	Pontic - resin with noble metal	$89.10
D6602	Inlay - cast high noble metal, two surfaces[11]	$79.20
D6603	Inlay - cast high noble metal, three or more surfaces[11]	$85.50
D6604	Inlay - cast predominantly base metal two surfaces[11]	$79.20
D6605	Inlay - cast predominantly base metal three or more surfaces[11]	$85.50
D6606	Inlay - cast noble metal, two surfaces[11]	$79.20
D6607	Inlay - cast noble metal, three or more surfaces[11]	$85.50
D6720	Crown - resin with high noble metal[11]	$98.10
D6721	Crown - resin with predominately base metal[11]	$85.50
D6722	Crown - resin with noble metal[11]	$89.10
D6750	Crown - porcelain fused to high noble metal[11]	$180.00
D6751	Crown - porcelain fused to predominantly base metal[11]	$91.80
D6752	Crown - porcelain fused to noble metal[11]	$95.40
D6780	Crown - 3/4 cast high noble metal[11]	$91.80
D6790	Crown - full cast high noble metal[11]	$175.50
D6791	Crown - full cast predominately base metal[11]	$85.50
D6792	Crown - full cast noble metal[11]	$89.10

[11] *Bridge retainers - initial placement of replacement.*

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PROCEDURES NOT LISTED ON THE SCHEDULE MAY BE CHARGED AT THE DENTIST'S USUAL AND CUSTOMARY FEE.

Limitations & Exclusions

Major restorative limitations:

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

- A denture, partial denture, or fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy, however, this provision will not apply if the Policy replaces a prior policy You had with another insurer and You are covered by this Policy on its Effective Date without a break in coverage provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
- The replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
- The replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
- The replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
- The replacement of teeth up to the normal complement of 32.

Exclusions:

Benefits will not be paid for:

- Procedures that are not included in the Schedule of Benefits; that are not medically necessary; that do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
- Any procedure, service, or supply that may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by Company;
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth that may be restored with an amalgam or composite resin filling;
- Appliances, inlays, cast restorations, or other laboratory prepared restorations used primarily for the purpose of splinting;
- Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
- Pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
- Charges for travel time; transportation costs; or professional advice given on the phone;
- Procedures performed by a Dentist who is a member of Your immediate family;
- Any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;
- Charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
- Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
- Charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside of the United States are limited to a maximum of $100 (U.S. dollars) per year;
- The care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
- Treatment for cosmetic purposes - facings on crowns or bridge units on molar teeth will always be considered cosmetic;
- Any services or supplies that do not meet the standards set by the American Dental Association or that are not reasonably necessary, or customarily used, for dental care;
- Procedures that are a covered expense under any other medical plan (established by the employer) that provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- An injury that arises out of or in the course of a job or employment for pay or profit for which benefits are available under any workers' compensation act or similar law; or
- Charges to the extent that they are more than the Reimbursement Rate. If the amount of the Reimbursement Rate for a service cannot be determined due to the unusual nature of the service, Company will determine the amount. Company will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors.

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