

# 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)
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### Calendar year maximum

Type I, II, III	\$1,000 per covered person
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### Waiting period

Type I, II, III	None
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ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
<b>TYPE I – PREVENTIVE DENTAL SERVICES</b>		
D0120	Periodic oral examination <sup>1</sup> . . . . .	\$11.70
D0140	Limited oral evaluation – (problem focused) <sup>1</sup> . . . . .	\$15.30
D0150	Comprehensive oral evaluation – new or established patient <sup>1</sup> . . . . .	\$15.30
D0180	Comprehensive periodontal evaluation – new or established patient <sup>1</sup> . . . . .	\$15.30
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

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
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 separate 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 <sup>2</sup> . . . . .	\$11.70
D2150	Amalgam – two surfaces, primary or permanent <sup>2</sup> . . . . .	\$18.00
D2160	Amalgam – three surfaces, primary or permanent <sup>2</sup> . . . . .	\$22.50
D2161	Amalgam – four or more surfaces, primary or permanent <sup>2</sup> . . . . .	\$28.80

<sup>1</sup> Covered twice per 12 consecutive months

<sup>2</sup> Multiple restorations on one surface will be covered as a single filling

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ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D2330	Resin-based composite – one surface, anterior <sup>3</sup>	\$15.30
D2331	Resin-based composite – two surfaces, anterior <sup>3</sup>	\$22.50
D2332	Resin-based composite – three surfaces, anterior <sup>3</sup>	\$30.60
D2335	Resin-based composite – four or more surfaces or involving incisal angle <sup>3</sup>	\$28.80
D2391	Resin-based composite – one surface, posterior <sup>3</sup>	\$11.70
D2392	Resin-based composite – two surfaces, posterior <sup>3</sup>	\$18.80
D2393	Resin-based composite – three surfaces, posterior <sup>3</sup>	\$22.50
D2394	Resin-based composite – four or more surfaces, posterior <sup>3</sup>	\$22.50
D2910	Recement inlay	\$11.70
D2920	Recement crown	\$11.70
D2940	Sedative filling (Covered as separate 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

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
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 <sup>4</sup>	\$51.30
D4211	Gingivectomy or gingivoplasty – one to three teeth, per quadrant <sup>4</sup>	\$13.50
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth, per quadrant <sup>4</sup>	\$57.60
D4241	Gingival flap procedure, including root planing – one to three teeth, per quadrant <sup>4</sup>	\$57.60
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 <sup>5</sup>	\$14.40
D4342	Periodontal scaling and root planing, one to three teeth, per quadrant <sup>5</sup>	\$14.40
D4355	Full mouth debridement to enable comprehensive eval. and diagnosis <sup>5</sup>	\$30.60
D4910	Periodontal maintenance <sup>5</sup>	\$19.80
D5510	Repair broken complete denture base <sup>6</sup>	\$26.10

<sup>3</sup> Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be deemed single surface restorations.

<sup>4</sup> Only one of these procedures is covered per area of the mouth.

<sup>5</sup> Covered twice per area of the mouth per 12 consecutive months.

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ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D5520	Replace missing or broken teeth – complete denture <sup>6</sup> . . . . .	\$26.10
D5610	Repair resin denture base <sup>6</sup> . . . . .	\$26.10
D5620	Repair cast framework <sup>6</sup> . . . . .	\$26.10
D5630	Repair or replace broken clasp <sup>6</sup> . . . . .	\$30.60
D5640	Replace broken teeth – per tooth <sup>6</sup> . . . . .	\$18.90
D5650	Add tooth to existing partial denture <sup>6</sup> . . . . .	\$36.00
D5660	Add clasp to existing partial denture <sup>6</sup> . . . . .	\$38.70
D5710	Rebase complete maxillary denture <sup>6</sup> . . . . .	\$76.50
D5711	Rebase complete mandibular denture <sup>6</sup> . . . . .	\$76.50
D5720	Rebase maxillary partial denture <sup>6</sup> . . . . .	\$76.50
D5721	Rebase mandibular partial denture <sup>6</sup> . . . . .	\$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 avulsed 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 – 1-3 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 – 1-3 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

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
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 <sup>7</sup> . . . . .	\$30.60
D9610	Therapeutic drug injection . . . . .	\$11.70
D9951	Occlusal adjustment – limited <sup>8</sup> . . . . .	\$14.40
D9952	Occlusal adjustment – Complete <sup>8</sup> . . . . .	\$36.90

### 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

<sup>6</sup> Covered only if repairs/adjustments more than 1 year after the initial insertion.

<sup>7</sup> Covered as a separate procedure only when required for covered complex oral surgical procedures as determined by the company.

<sup>8</sup> Covered only when performed with periodontal surgery or nonsurgical TMJ dysfunction treatment.

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## Schedule of benefits

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 <sup>9</sup> . . . . .	\$8.10
D5411	Adjust complete denture – lower <sup>9</sup> . . . . .	\$8.10
D5421	Adjust partial denture – upper <sup>9</sup> . . . . .	\$8.10
D5422	Adjust partial denture – lower <sup>9</sup> . . . . .	\$8.10
D5730	Reline complete upper denture (chairside) <sup>10</sup> . . . . .	\$32.40
D5731	Reline complete lower denture (chairside) <sup>10</sup> . . . . .	\$32.40
D5740	Reline upper partial denture (chairside) <sup>10</sup> . . . . .	\$26.10
D5741	Reline lower partial denture (chairside) <sup>10</sup> . . . . .	\$26.10
D5750	Reline complete upper denture (laboratory) <sup>10</sup> . . . . .	\$47.70
D5751	Reline complete lower denture (laboratory) <sup>10</sup> . . . . .	\$47.70
D5760	Reline upper partial denture (laboratory) <sup>10</sup> . . . . .	\$41.40

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D5761	Reline lower partial denture (laboratory) <sup>10</sup> . . . . .	\$41.40
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 <sup>11</sup> . . . . .	\$79.20
D6603	Inlay – cast high noble metal, three or more surfaces <sup>11</sup> . . . . .	\$85.50
D6604	Inlay – cast predominantly base metal two surfaces <sup>11</sup> . . . . .	\$79.20
D6605	Inlay – cast predominantly base metal three or more surfaces <sup>11</sup> . . . . .	\$85.50
D6606	Inlay – cast noble metal, two surfaces <sup>11</sup> . . . . .	\$79.20
D6607	Inlay – cast noble metal, three or more surfaces <sup>11</sup> . . . . .	\$85.50
D6720	Crown – resin with high noble metal <sup>11</sup> . . . . .	\$98.10
D6721	Crown – resin with predominately base metal <sup>11</sup> . . . . .	\$85.50
D6722	Crown – resin with noble metal <sup>11</sup> . . . . .	\$89.10
D6750	Crown – porcelain fused to high noble metal <sup>11</sup> . . . . .	\$180.00
D6751	Crown – porcelain fused to predominately base metal <sup>11</sup> . . . . .	\$91.80
D6752	Crown – porcelain fused to noble metal <sup>11</sup> . . . . .	\$95.40
D6780	Crown – 3/4 cast high noble metal <sup>11</sup> . . . . .	\$91.80
D6790	Crown – full cast high noble metal <sup>11</sup> . . . . .	\$175.50
D6791	Crown – full cast predominately base metal <sup>11</sup> . . . . .	\$85.50
D6792	Crown – full cast noble metal <sup>11</sup> . . . . .	\$89.10

<sup>9</sup> Covered only once per 12 consecutive months and only if done more than one year after the initial insertion of the denture.  
<sup>10</sup> Covered only if relining is done more than 1 year after the initial insertion and then not more than once per 2-year period.  
<sup>11</sup> Bridge retainers – initial placement of replacement.

# Schedule B Indemnity plan

## People First Plan Code #4084

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

### Limitations and 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, 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.