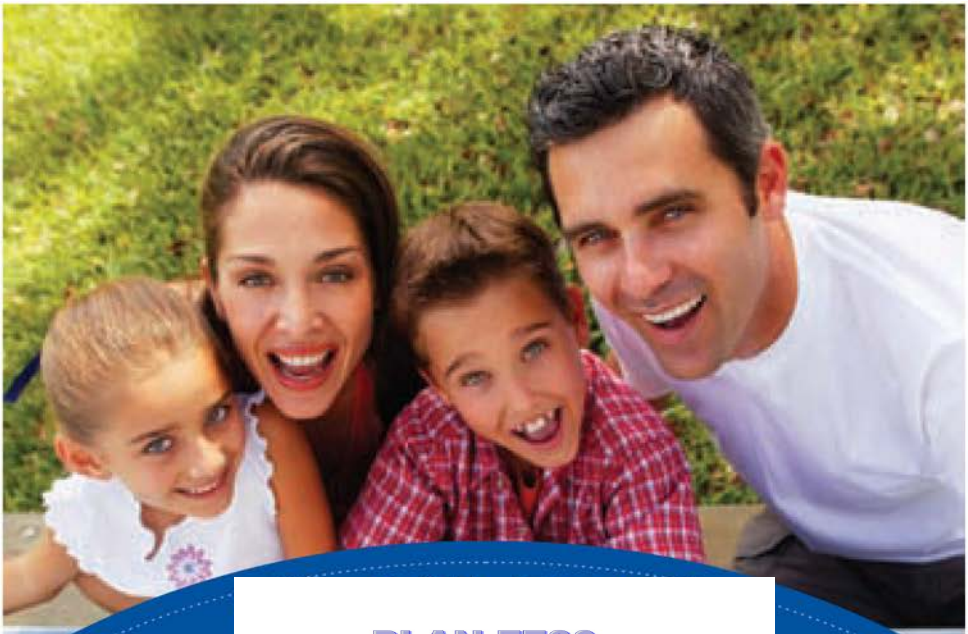

PLAN 7780

Western Dental®
BENEFITS DIVISION

PLAN 7780 – COPAYMENT SCHEDULE

ADA CODE	DESCRIPTION	CO-PAYMENT REQUIRED
CLINICAL ORAL EVALUATIONS		
D0120	Periodic oral examination - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for patient under three 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
D0180	Comprehensive periodontal evaluation - new or established patient	$0
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)		
D0210	Intraoral - complete series (including bitewings)	$0
D0220	Intraoral - periapical first film	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0273	Bitewings - three films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings - 7 to 8 films	$0
D0330	Panoramic film	$25
D0340	Cephalometric Film	$0
D0350	Oral/Facial Images	$0
TESTS AND EXAMINATIONS		
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
DENTAL PROPHYLAXIS		
D1110	Prophylaxis - adult	$10
	Each additional after 2 in 12 months	$45
D1120	Prophylaxis - child	$0
	Each additional after 2 in 12 months	$45
TOPICAL FLUORIDE TREATMENT (office procedure)		
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$10
D1208	Tropical Fluoride-excluding varnish-child to 19, limited 2 per yr	$0

This matrix is a representative listing of co-payment amounts, by plan.

PLAN 7780 – COPAYMENT SCHEDULE

ADA CODE	DESCRIPTION	CO-PAYMENT REQUIRED
OTHER PREVENTIVE SERVICES		
D1310	Nutritional Counseling for control of dental disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
SPACE MAINTENANCE (passive appliances)		
D1510	Space maintainer - fixed - unilateral	$100
D1515	Space maintainer - fixed - bilateral	$125
D1520	Space maintainer - removable - unilateral	$135
D1525	Space maintainer - removable - bilateral	$160
D1550	Re-cementation of space maintainer	$0
D1555	Removal of fixed space maintainer	$45
AMALGAM RESTORATIONS (including polishing)		
D2140	Amalgam - one surface, primary or permanent	$30
D2150	Amalgam - two surfaces, primary or permanent	$40
D2160	Amalgam - three surfaces, primary or permanent	$40
D2161	Amalgam - four or more surfaces, primary or permanent	$55
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
D2330	Resin-based composite - one surface, anterior	$30
D2331	Resin-based composite - two surfaces, anterior	$40
D2332	Resin-based composite - three surfaces, anterior	$40
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$55
D2390	Resin-based composite crown, anterior	$80
D2391	Resin-based composite - one surface, posterior	$65
D2392	Resin-based composite - two surfaces, posterior	$75
D2393	Resin-based composite - three surfaces, posterior	$85
D2394	Resin-based composite - four or more surfaces, posterior	$95
INLAY/ONLAY RESTORATIONS		
D2510 u	Inlay - metallic - one surface	$165
D2520 u	Inlay - metallic - two surfaces	$255
D2530 u	Inlay - metallic - three or more surfaces	$255
D2542 u	Onlay - metallic - two surfaces	$290
D2543 u	Onlays - metallic - three surfaces	$290
D2544 u	Onlays - metallic - four or more surfaces	$310
CROWNS - SINGLE RESTORATIONS ONLY		
D2710	Crown - resin-based composite (indirect)	$205
D2712	Crown - 3/4 resin-based composite (indirect)	$205

PLAN 7780 – COPAYMENT SCHEDULE

ADA CODE	DESCRIPTION	CO-PAYMENT REQUIRED
D2720 u	Crown - resin with high noble metal	$385
D2721	Crown - resin with predominantly base metal	$385
D2722 u	Crown - resin with noble metal	$385
D2740	Crown - porcelain/ceramic substrate	$475
D2750 u	Crown - porcelain fused to high noble metal	$410
D2751	Crown - porcelain fused to predominantly base metal	$410
D2752 u	Crown - porcelain fused to noble metal	$410
D2780 u	Crown - 3/4 cast high noble metal	$410
D2781	Crown - 3/4 cast predominantly base metal	$410
D2782 u	Crown - 3/4 cast noble metal	$410
D2783	Crown - 3/4 porcelain/ceramic	$465
D2790 u	Crown - full cast high noble metal	$410
D2791	Crown - full cast predominantly base metal	$410
D2792 u	Crown - full cast noble metal	$410
D2794 u	Crown - titanium	$410
D2799	Provisional crown - To be used at least 6 months during healing	$125

OTHER RESTORATIVE SERVICES

D2910	Recement inlay, onlay, or partial coverage restoration	$30
D2915	Recement cast or prefabricated post and core	$30
D2920	Recement crown	$30
D2930	Prefabricated stainless steel crown - primary tooth	$100
D2931	Prefabricated stainless steel crown - permanent tooth	$105
D2932	Prefabricated resin crown	$125
D2933	Prefabricated stainless steel crown with resin window	$125
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$125
D2940	Sedative filling	$0
D2950	Core buildup, involving and including any pins	$70
D2951	Pin retention - per tooth, in addition to restoration	$0
D2952	Post and core in addition to crown, indirectly fabricated	$100
D2953	Each additional indirectly fabricated post - same tooth	$10
D2954	Prefabricated post and core in addition to crown	$100
D2955	Post removal (not in conjunction with endodontic therapy)	$0
D2957	Each additional prefabricated post - same tooth	$10
D2970	Temporary crown (fractured tooth)	$125
D2971	Additional procedures to construct new crown under existing partial denture framework	$95
D2980	Crown repair, by report	$0

PULP CAPPING

D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0

PLAN 7780 – COPAYMENT SCHEDULE

ADA CODE	DESCRIPTION	CO-PAYMENT REQUIRED
PULPOTOMY		
D3220	Therapeutic pulpotomy (excluding final restoration)	$45
D3221	Pulpal debridement, primary and permanent teeth	$45
ENDODONTIC THERAPY ON PRIMARY TEETH		
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$55
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$70
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)		
D3310	Anterior (excluding final restoration)	$200
D3320	Bicuspid (excluding final restoration)	$300
D3330	Molar (excluding final restoration)	$550
ENDODONTIC RETREATMENT		
D3346	Retreatment of previous root canal therapy - anterior	$450
D3347	Retreatment of previous root canal therapy - bicuspid	$500
D3348	Retreatment of previous root canal therapy - molar	$675
APICOECTOMY/PERIRADICULAR SERVICES		
D3410	Apicoectomy/periradicular surgery - anterior	$475
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$475
D3425	Apicoectomy/periradicular surgery - molar (first root)	$505
D3426	Apicoectomy/periradicular surgery (each additional root)	$140
D3430	Retrograde filling - per root	$0
D3450	Root amputation - per root	$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	$105
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 bounded teeth spaces per quadrant	$100
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$55
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$135

PLAN 7780 – COPAYMENT SCHEDULE

ADA CODE	DESCRIPTION	CO-PAYMENT REQUIRED
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$100
D4245	Apically positioned flap	$275
D4249	Clinical crown lengthening - hard tissue	$475
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$600
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$450
D4263	Bone replacement graft - first site in quadrant	$475
D4264	Bone replacement graft - each additional site in quadrant	$275
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$275
NON-SURGICAL PERIODONTAL SERVICES		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$100
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$75
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$70
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report	$95
OTHER PERIODONTAL SERVICES		
D4910	Periodontal maintenance	$90
D4999	Irrigation - Per Quadrant	$75
COMPLETE DENTURES (including routine post-delivery care)		
D5110	Complete denture - maxillary	$525
D5120	Complete denture - mandibular	$525
D5130	Immediate denture - maxillary	$580
D5140	Immediate denture - mandibular	$580
PARTIAL DENTURES (including routine post-delivery care)		
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$315
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$315
D5213	Maxillary partial denture - cast metal framework with resindenture bases (incuding any conventional clasps, rests and teeth)	$500
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$500

PLAN 7780 – COPAYMENT SCHEDULE

ADA CODE	DESCRIPTION	CO-PAYMENT REQUIRED
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$500
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$500
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$370
ADJUSTMENTS TO DENTURES		
D5410	Adjust complete denture - maxillary	$45
D5411	Adjust complete denture - mandibular	$45
D5421	Adjust partial denture - maxillary	$45
D5422	Adjust partial denture - mandibular	$45
REPAIRS TO COMPLETE DENTURES		
D5510	Repair broken complete denture base	$70
D5520	Replace missing or broken teeth - complete denture (each tooth)	$70
REPAIRS TO PARTIAL DENTURES		
D5610	Repair resin denture base	$70
D5620	Repair cast framework	$70
D5630	Repair or replace broken clasp	$70
D5640	Replace broken teeth - per tooth	$70
D5650	Add tooth to existing partial denture	$70
D5660	Add clasp to existing partial denture	$70
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$335
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$335
DENTURE REBASE PROCEDURES		
D5710	Rebase complete maxillary denture	$125
D5711	Rebase complete mandibular denture	$125
D5720	Rebase maxillary partial denture	$125
D5721	Rebase mandibular partial denture	$125
DENTURE RELINE PROCEDURES		
D5730	Reline complete maxillary denture (chairside)	$70
D5731	Reline complete mandibular denture (chairside)	$70
D5740	Reline maxillary partial denture (chairside)	$70
D5741	Reline mandibular partial denture (chairside)	$70
D5750	Reline complete maxillary denture (laboratory)	$125
D5751	Reline complete mandibular denture (laboratory)	$125
D5760	Reline maxillary partial denture (laboratory)	$125
D5761	Reline mandibular partial denture (laboratory)	$125

PLAN 7780 – COPAYMENT SCHEDULE

ADA CODE	DESCRIPTION	CO-PAYMENT REQUIRED
D5810	Interim complete denture (maxillary)	$480
D5811	Interim complete denture (mandibular)	$480
OTHER REMOVABLE PROSTHETIC SERVICES		
D5820	Interim partial denture (maxillary)	$255
D5821	Interim partial denture (mandibular)	$255
D5850	Tissue conditioning, maxillary	$100
D5851	Tissue conditioning, mandibular	$100
FIXED PARTIAL DENTURE PONTICS		
D6205	Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	$400
D6210 u	Pontic - cast high noble metal	$410
D6211	Pontic - cast predominantly base metal	$410
D6212 u	Pontic - cast noble metal	$410
D6214 u	Pontic - titanium	$410
D6240 u	Pontic - porcelain fused to high noble metal	$410
D6241	Pontic - porcelain fused to predominantly base metal	$410
D6242 u	Pontic - porcelain fused to noble metal	$410
D6245	Pontic - porcelain/ceramic	$465
D6250 u	Pontic - resin with high noble metal	$410
D6251	Pontic - resin with predominantly base metal	$410
D6252 u	Pontic - resin with noble metal	$410
FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS		
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$250
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6710	Crown - indirect resin based composite	$440
D6720 u	Crown - resin with high noble metal	$385
D6721	Crown - resin with predominantly base metal	$385
D6722 u	Crown - resin with noble metal	$440
D6740	Crown - porcelain/ceramic	$440
D6750 u	Crown - porcelain fused to high noble metal	$385
D6751	Crown - porcelain fused to predominantly base metal	$385
D6752 u	Crown - porcelain fused to noble metal	$385
D6780 u	Crown - 3/4 cast high noble metal	$385
D6781	Crown - 3/4 cast predominantly base metal	$385
D6782 u	Crown - 3/4 cast noble metal	$385
D6783	Crown - 3/4 cast porcelain/ceramic	$440
D6790 u	Crown - full cast high noble metal	$385
D6791	Crown - full cast predominantly base metal	$385

PLAN 7780 – COPAYMENT SCHEDULE

ADA CODE	DESCRIPTION	CO-PAYMENT REQUIRED
D6792 u	Crown - full cast noble metal	$385
D6794 u	Crown - titanium	$385

OTHER FIXED PARTIAL DENTURE SERVICES

D6930	Recement fixed partial denture	$0
D6940	Stress breaker	$180
D6980	Fixed partial denture repair, by report	$0

EXTRACTIONS

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7111	Coronal remnants - deciduous tooth	$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$95

SURGICAL EXTRACTIONS

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7210	Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$125
D7220	Removal of impacted tooth - soft tissue	$175
D7230	Removal of impacted tooth - partially bony	$250
D7240	Removal of impacted tooth - completely bony	$310
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$310
D7250	Surgical removal of residual tooth roots (cutting procedure)	$250

OTHER SURGICAL PROCEDURES

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$340
D7280	Surgical access of an unerupted tooth	$70
D7283	Placement of device to facilitate eruption of impacted tooth	$30
D7285	Biopsy of oral tissue - hard (bone, tooth)	$175
D7286	Biopsy of oral tissue - soft (all others)	$175
D7288	Brush biopsy - transepithelial sample collection	$65

If this matrix conflicts with a member's Plan Documents, the Plan Documents will govern.

PLAN 7780 – COPAYMENT SCHEDULE

ADA CODE	DESCRIPTION	CO-PAYMENT REQUIRED
ALVEOLOPLASTY (surgical preparation of ridge for dentures)		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$45
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$45
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	$175
D7471	Removal of lateral exostosis (maxilla or mandible)	$620
D7485	Surgical reduction of osseous tuberosity	$615
SURGICAL INCISION		
D7510	Incision and drainage of abscess - intraoral soft tissue	$70
D7520	Incision and drainage of abscess - extraoral soft tissue	$105
OTHER REPAIR PROCEDURES		
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$185
D7963	Frenuloplasty	$185
D7970	Excision of hyperplastic tissue - per arch	$125
D7971	Excision of pericoronal gingiva	$70
COMPREHENSIVE ORTHODONTIC TREATMENT		
D8010	Limited orthodontic treatment of the primary dentition	$1,500
D8020	Limited orthodontic treatment of the transitional dentition	$1,500
D8030	Limited orthodontic treatment of the adolescent dentition	$1,500
D8040	Limited orthodontic treatment of the adult dentition	$1,500
D8050	Interceptive orthodontic treatment of the primary dentition	$1,750
D8060	Interceptive orthodontic treatment of the transitional dentition	$1,750
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,400
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,400
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,700
OTHER ORTHODONTIC SERVICES		
D8660	Pre-orthodontic treatment visit	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250
D8999	Orthodontic records fee	$275

This matrix is a representative listing of co-payment amounts, by plan.

PLAN 7780 – COPAYMENT SCHEDULE

ADA CODE	DESCRIPTION	CO-PAYMENT REQUIRED
UNCLASSIFIED TREATMENT		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$45
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	$0
D9223	Deep sedation/general anesthesia - each additional 15 minutes	$135
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$45
D9243	Intravenous conscious sedationalgesia - each 15 minutes	$100
PROFESSIONAL CONSULTATION		
D9310	Consultation - (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0
PROFESSIONAL VISITS		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit, after regularly scheduled hours	$95
MISCELLANEOUS SERVICES		
D9910	Application of desensitizing medicament	$35
D9940	Occlusal guard, by report	$250
D9951	Occlusal adjustment - limited	$45
D9952	Occlusal adjustment - complete	$125
D9975	External bleaching - per arch - take home trays	$100
D9986	Missed Appointment-without notice-per 15 mins app time	$15
D9987	Cancelled Appointment-Without 24 hr notice-per 15 mins	$15

If this matrix conflicts with a member's Plan Documents, the Plan Documents will govern.

PLAN 7780 – COPAYMENT SCHEDULE

ADA CODE	DESCRIPTION	CO-PAYMENT REQUIRED
COSMETIC PROCEDURES		
D2610	Inlay - porcelain/ceramic - 1 surface	$510
D2620	Inlay - porcelain/ceramic - 2 surfaces	$535
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$570
D2642	Onlay, porcelain/ceramic - 2 surfaces	$555
D2643	Onlay, porcelain/ceramic - 3 surfaces	$600
D2651	Inlay - resin-based composite - 2 surfaces	$400
D2652	Inlay - resin-based composite - 3 or more surfaces	$420
D2662	Onlay - resin-based composite - 2 surfaces	$365
D2663	Onlay - resin-based composite - 3 surfaces	$425
D2962	Labial veneer (porcelain laminate) - laboratory]	$590
#	Lumineer	$600
	Rebond Veneer	$80
D6010 #	Surgical placement of implant body: endosteal implant	$1,690
D6058 #	Abutment supported porcelain/ceramic crown	$960
D6059 #	Abutment supported porcelain fused to metal crown (high noble metal)	$965
D6060 #	Abutment supported porcelain fused to metal crown (predominantly base metal)	$915
D6061 #	Abutment supported porcelain fused to metal crown (noble metal)	$930
D6062 #	Abutment supported cast metal crown (high noble metal)	$925
D6063 #	Abutment supported cast metal crown (predominantly base metal)	$800
D6064 #	Abutment supported cast metal crown (noble metal)	$840
D6065 #	Implant supported porcelain/ceramic crown	$955
D6066 #	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$935
D6067 #	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$910
D6068 #	Abutment supported retainer for porcelain/ceramic FPD	$975
D6069 #	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$965
D6070 #	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$915
D6071 #	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$930
D6072 #	Abutment supported retainer for cast metal FPD (high noble metal)	$950
D6073 #	Abutment supported retainer for cast metal FPD (predominantly base metal)	$860
D6074 #	Abutment supported retainer for cast metal FPD (noble metal)	$925
D6094 #	Abutment supported crown - (titanium)	$600
D6194 #	Abutment supported retainer crown for FPD (titanium)	$500

u Metal charges apply to a maximum of $125 # Where available

This matrix is a representative listing of co-payment amounts, by plan.

LIMITATIONS & EXCLUSIONS

LIMITATIONS

The following Limitations apply to Services Covered in the Schedule of Benefits.

Diagnostic

Full Mouth X-Ray, Panoramic Film, Cephalometric Film, and Oral/Facial Images - once in a two-year period.

Coverage for bitewing X-rays - no more than one series of four (4) films in any six-month period.

Preventive

Prophylaxis covered twice in twelve (12) months. Examples of situations where an additional prophylaxis within the twelve (12) month period may be necessary for the dental health of the Member and may be covered are:

1) Pregnancy
2) Pre-radiation therapy as ordered by an oncologist
3) Gingival hyperplasia due to the use of Dilantin or other medications
4) Inflammation due to syphilis or tuberculosis
5) Chronic menopausal gingivostomatitis
6) Leukemia or HIV induced gingivitis

Fluoride Treatments (Topical Application and Fluoride Varnish).

Topical Fluoride Treatments are limited to two (2) treatments in a 12 consecutive month period.

Restorative Services

Crowns, Inlays and Onlays

Will be covered when a filling cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental care. (Example: buccal or lingual walls are either fractured or decayed to the extent that the tooth cannot hold a filling).

Use of precious metal in fabrication of a crown, inlay or onlay is considered elective and an additional metal charge will apply.

Endodontics

Endodontic Re-treatments (ADA Codes D3346, D3347 and D3348) are limited to one per tooth per lifetime.

Apicoectomies (ADA Codes D3410, D3421, D3425 and D3426) are limited to one per root per lifetime.

Periodontics

Scaling and Root Planing (per quadrant) and Full Mouth Debridement are covered once every twelve months.

Crown lengthening (ADA Code D4249) is limited to one (1) per tooth per lifetime.

Complete and Partial Dentures

Replacement of an existing appliance will be covered if the appliance is over five years old and cannot be made serviceable by reline, rebase or repair.

Tooth Additions and Repair to Existing Denture, Repair of appliances damaged due to Member abuse, Denture Reline and Rebase and Relines of full or partial dentures are limited to twice in a calendar year.

Fixed Bridge(s), Pontics, and Crowns

Replacement of an existing appliance will be covered if the appliance is over five years old, is defective and cannot be made serviceable.

Fixed bridges are a covered benefit when a removable partial denture cannot satisfactorily restore the case in accordance with professionally recognized standards of dental practice.

If the Member elects a fixed bridge instead of the covered removable partial denture, the Member's benefit for the partial denture will be applied to the Member's cost for the fixed bridge as follows:

Copayment for the fixed bridge = UCR Cost of the Fixed Bridge – UCR Cost of the Removable Partial Denture + the Copayment of the Removable Partial Denture.

If the Member has unreplaced missing teeth on opposite sides of the same arch, a removable partial denture is considered the covered benefit.

The Plan provides coverage for up to six units of crown and/or fixed bridges in the same treatment plan.

Each tooth treated with a crown and replaced tooth in a fixed bridge ("pontic") included in the treatment plan is referred to as a "unit". When a treatment plan consists of more than six units of crowns and/or bridges, the term "full mouth reconstruction" is used to describe the treatment plan, and units in excess of six are not a Covered Service, and the Member will be charged at the Participating Provider's usual and customary rate.

LIMITATIONS & EXCLUSIONS

Pediatric Dentistry Referrals

Referral for pediatric dentistry services for children under the age of six years must be pre-authorized by the Plan. Exceptions for physical or mental handicaps or medically compromised individuals, when confirmed by the treating physician, may be considered on an individual basis with prior approval from the Plan.

Limitations apply unless the treating Participating Provider can document that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice, at which point such services will be covered as set forth in the accompanying Schedule of Benefits.

EXCLUSIONS

The following dental procedures and services are excluded from this coverage:

Preventive

Supplies used for oral hygiene, plaque control, oral physiotherapy instruction, and chemical analysis of saliva.

Restorative Services

Crowns, Inlays and Onlays

Crowns, inlays or onlays that are only for cosmetic purposes.

Crowns, inlays or onlays that are lost, stolen, or damaged due to Member abuse, misuse or neglect.

Crowns and pontics supported on a dental implant.

Charges for specialized techniques involving precision attachments, and personalization or characterization of such appliances.

Periodontics

Soft Tissue Grafts.

Complete and Partial Dentures

Replacement or repair of a lost, stolen, or damaged appliance due to Member abuse.

Removable Prosthetic Services and supplies that are only for cosmetic purposes.

Implant supported dentures, unless specifically listed as a covered benefit under your plan.

Fixed Bridges

Replacement or repair of a lost, stolen, or damaged bridge due to Member abuse.

Distal extension posterior cantilever pontics, which are supported at the front end only.

Implant supported bridges, unless specifically listed as a covered benefit under your plan.

Oral Surgery

Removal of third molars (wisdom teeth), supernumerary teeth or other teeth that are impacted that do not have associated pathology.

Removal of teeth for orthodontic purposes only.

General Exclusions

Treatment by someone other than a Participating Provider or dental auxiliary under the direction of a Participating Provider, except for Emergency treatment as provided in the EOC (Evidence of Coverage) or upon prior authorization by the Plan.

Charges for medical treatment, prescriptions or other charges not directly related to dental services provided.

Hospitalization costs for any dental procedure, including all hospital services, anesthesia and medications.

Any dental treatment that is determined by the Plan to be the responsibility of Worker's Compensation, employer, the health care plan, 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.

Treatment of malignancies, neoplasms, and cysts, unless specifically listed as a Covered Service on the Schedule of Benefits.

Treatment of Myofacial pain or disturbances of the Temporomandibular Joint (TMJ), including correction of occlusion or "occlusal equilibration".

Procedures, restorations, and appliances to correct congenital or developmental malformations.

Services and supplies that are not deemed necessary for a Member's dental health in accordance with professionally recognized standards of dental practice.

LIMITATIONS & EXCLUSIONS

Dental expenses incurred in connection with any portion of the dental services provided prior to the effective date of coverage or dental expenses incurred in connection with any dental procedure started after termination of coverage.

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.

Appliances to correct and control harmful habits (e.g., tongue thrust and thumb sucking).

ORTHODONTIC COVERAGES

The Plan's orthodontic benefit covers only basic orthodontic treatment to resolve malocclusion and establish optimal dental and facial esthetics. Orthodontic treatment may involve the primary, transitional or permanent dentition. All orthodontic services must be provided by a Participating Provider to be covered under the Benefit Plan. Refer to the "Orthodontics" category of your Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

ORTHODONTIC LIMITATIONS

Benefits for any phase of Orthodontic treatment are limited to a maximum of 24 months. Treatment extending beyond the 24th month may be charged a monthly continuation fee per the Member's Orthodontic contract with the provider.

ORTHODONTIC EXCLUSIONS

The following dental procedures and services are excluded from this coverage:

Special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders).

TMJ/Myofunctional Therapy – Therapy for treatment of jaw joint problems, and teaching and therapy for improper swallowing and tongue posture.

Surgical Orthodontics – Orthodontic treatment in conjunction with Orthognathic surgery.

Orthognathic Surgery – Surgery to move the jaw bones into alignment.

Treatment of Cleft Palate – Treatment for problems involving holes or voids in the bone that forms the roof of the mouth.

Removable Orthodontic Appliance Therapy – The use of appliances that are removable from the mouth by the Member and which are used to hold or move and align teeth.

Treatment of Hormonal Imbalances – The treatment of hormone imbalances that influence growth and influence the ability of teeth to move without root damage.

Orthodontic Treatment Commenced Prior to Coverage – An orthodontic treatment program which commenced before the Member enrolled in this Benefit Plan.

Retreatment of Orthodontic Cases – The treatment of orthodontic problems that have been treated before.

Repair or replacement of lost, stolen, damaged or broken appliances, including retainers, brackets, bands, wires or other materials supplied by the orthodontist.

Extractions for Orthodontic Purposes – Removal of teeth specifically to correct orthodontic problems or due to lack of eruptive space are not covered.

Post-treatment Records - X-rays, photographs and models following orthodontic treatment.

NOTE: THIS IS ONLY A BRIEF SUMMARY OF THE PLAN

The Group Dental Service Contract must be consulted to determine the exact terms and conditions of coverage. An Evidence of Coverage will be sent to you upon enrollment.

If you wish to review an Evidence of Coverage prior to enrollment, you may request a copy by calling the Customer Service Department at (800) 992-3366

Western Dental®

BENEFITS DIVISION

530 South Main Street
Orange, CA 92868

Customer Service: 800-992-3366
www.westerndentalbenefitsdivision.com

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