Schedule B Indemnity plan
People First Plan Code #4084

Schedule of benefits

Calendar year deductible	
Type I, II, III	$0 individual $0 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—established patient[1]	$23
D0140	Limited oral evaluation—problem focused[1]	$31
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver[1]	$31
D0150	Comprehensive oral evaluation - new or established patient[1]	$31
D0180	Comprehensive periodontal evaluation - new or established patient[1]	$31
D0210	X-ray intraoral—complete series of radiographic images (once per three year period)	$61
D0220	X-ray intraoral—periapical, first radiographic image	$13
D0230	X-ray intraoral—periapical, each additional radiographic image	$13
D0240	X-rays intraoral—occlusal radiographic image	$16
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$22
D0251	Extra-oral posterior dental radiographic image[1]	$32
D0270	X-ray bitewing—single radiographic image[1]	$20
D0272	X-ray bitewings—two radiographic images[1]	$25
D0273	Bitewings – three radiographic images[1]	$32
D0274	Bitewings—four radiographic images[1]	$32
D0330	Panoramic radiographic image (covered once per three year period)	$47
D0415	Collection of microorganisms for culture & sensitivity	$36
D1110	Prophylaxis—adult[1]	$38
D1120	Prophylaxis—child[1]	$36
D1206	Topical application of fluoride varnish (Covered twice per 12 consecutive months for a dependent child under 16)	$31
D1208	Topical application of fluoride – excluding varnish (Covered twice per 12 consecutive months for a dependent child under 16)	$31
D1351	Sealant—per tooth (Covered once per 12 consecutive months for a dependent child under age 13)	$13
D1510	Space maintainer—fixed, unilateral	$160
D1515	Space maintainer—fixed, bilateral	$216
D1520	Space maintainer—removable, unilateral	$202
D1525	Space maintainer—removable, bilateral	$220
D1550	Re-cement or re-bond space maintainer	$27
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$90
D7286	Incisional biopsy of oral tissue-soft	$61
D9110	Palliative (emergency) treatment of dental pain—minor procedure	$29
TYPE II – BASIC DENTAL SERVICES		
D2140	Amalgam—one surface, primary or permanent[2]	$19
D2150	Amalgam—two surfaces, primary or permanent[2]	$29
D2160	Amalgam—three surfaces, primary or permanent[2]	$36
D2161	Amalgam—four or more surfaces, primary or permanent[2]	$46
D2330	Resin based composite—one surface, anterior[3]	$24
D2331	Resin based composite—two surfaces, anterior[3]	$36
D2332	Resin based composite—three surfaces, anterior[3]	$49
D2335	Resin based composite—four or more surfaces or involving incisal angle (anterior)[3]	$46
D2391	Resin based composite—one surface, posterior[3]	$19
D2392	Resin based composite—two surfaces, posterior[3]	$29
D2393	Resin based composite—three surfaces, posterior[3]	$36
D2394	Resin based composite—four or more surfaces, posterior[3]	$36
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$19
D2920	Re-cement or re-bond crown	$19
D2940	Protective restoration (Covered as separate procedure if no other service, except X-rays, rendered during the visit)	$20

[1] Covered twice per 12 consecutive months
[2] Multiple restorations on one surface will be covered as a single filling
[3] Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be deemed single surface restorations

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D2950	Core buildup, including any pins when required	$58
D2951	Pin retention—per tooth, in addition to restoration	$27
D3220	Therapeutic pulpotomy (excluding final restoration)	$33
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	$33
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$259
D3320	Endodontic therapy, premolar tooth (excluding final restorations)	$317
D3330	Endodontic therapy, molar tooth (excluding final restorations)	$389
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$73
D3352	Apexification/recalcification—interim medication replacement (includes any necessary radiographs)	$73
D3353	Apexification/recalcification—final visit (includes any necessary radiographs)	$73
D3410	Apicoectomy—anterior	$114
D3421	Apicoectomy—premolar (first root)	$114
D3425	Apicoectomy—molar (first root)	$114
D3426	Apicoectomy (each additional root)	$114
D3430	Retrograde filling—per root	$42
D3450	Root amputation—per root (not covered in conjunction with procedure D3920)	$62
D3920	Hemisection (including any root removal), not including root canal therapy	$62
D4210	Gingivectomy/gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)[4]	$82
D4211	Gingivectomy/gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)[4]	$22
D4240	Gingival flap procedure, including root planing—four or more contiguous teeth or tooth bounded spaces, per quadrant (Covered once per 12 consecutive months)[4]	$92
D4241	Gingival flap procedure, including root planing—one to three contiguous teeth or tooth bounded spaces, per quadrant (Covered once per 12 consecutive months)[4]	$92
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)	$153
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)	$153
D4270	Pedicle soft tissue graft procedure (Covered once per 12 consecutive months)	$92
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft (Covered once per 12 consecutive months)	$102
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site (Covered once per 12 consecutive months)	$102
D4320	Provisional splinting—intracoronal	$29
D4321	Provisional splinting—extracoronal.	$29
D4341	Periodontal scaling and root planing – four or more teeth per quadrant[5]	$23
D4342	Periodontal scaling and root planing – one to three teeth per quadrant[5]	$23
D4355	Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit[5]	$49
D4910	Periodontal maintenance (covered only after active periodontal therapy)[5]	$32
D5511	Repair broken complete denture base, mandibular[6]	$42
D5512	Repair broken complete denture base, maxillary[6]	$42
D5520	Replace missing or broken teeth—complete denture (each tooth)[6]	$42
D5611	Repair resin partial denture base, mandibular[6]	$42
D5612	Repair resin partial denture base, maxillary[6].	$42
D5621	Repair cast partial framework, mandibular[6]	$42
D5622	Repair cast partial framework, maxillary[6]	$42
D5630	Repair or replace broken clasp—per tooth[6].	$49
D5640	Replace broken teeth—per tooth[6].	$30
D5650	Add tooth to existing partial denture[6]	$58
D5660	Add clasp to existing partial denture—per tooth[6]	$62
D5710	Rebase complete maxillary denture[6]	$122
D5711	Rebase complete mandibular denture[6]	$122
D5720	Rebase maxillary partial denture[6].	$122
D5721	Rebase mandibular partial denture[6].	$122

[4] Only one of these procedures is covered per area of the mouth.
[5] Covered twice per area of the mouth per 12 consecutive months.
[6] Covered only if repairs/adjustments more than 1 year after the initial insertion.

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ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D6930	Re-cement or re-bond fixed partial denture (per unit)	$26
D7111	Extraction, coronal remnants – primary tooth	$23
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$23
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$42
D7220	Removal of impacted tooth—soft tissue	$58
D7230	Removal of impacted tooth—partially bony	$73
D7240	Removal of impacted tooth—completely bony	$98
D7250	Surgical removal of residual tooth roots (cutting procedure)	$46
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$76
D7272	Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)	$82
D7310	Alveoloplasty in conjunction with extractions— four or more teeth or tooth spaces, per quadrant	$35
D7311	Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$35
D7320	Alveoloplasty not in conjunction with extractions— four or more teeth or tooth spaces, per quadrant	$40
D7321	Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$40
D7340	Vestibuloplasty – ridge extension (second epithelialization)	$62
D7350	Vestibuloplasty – ridge extension (incl tissue procedures)	$122
D7510	Incision and drainage of abscess— intraoral soft tissue	$36
D7520	Incision and drainage of abscess – extraoral soft tissue	$55
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	$53
D7970	Excision hyperplastic tissue—per arch	$62
D9222	Deep sedation/general anesthesia – first 15 minute[7]	$54
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment[7]	$49
D9610	Therapeutic parenteral drug, single administration	$19
D9951	Occlusal adjustment – limited[8]	$23
D9952	Occlusal adjustment – complete[8]	$59

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
TYPE III – MAJOR DENTAL SERVICES		
D0470	Diagnostic casts	$24
D2510	Inlay—metallic, one surface	$92
D2520	Inlay—metallic, two surfaces	$127
D2530	Inlay—metallic, three or more surfaces	$137
D2610	Inlay—porcelain/ceramic, one surface	$42
D2620	Inlay—porcelain/ceramic, two surfaces	$84
D2630	Inlay—porcelain/ceramic, three or more surfaces	$125
D2710	Crown—resin based composite, indirect	$82
D2720	Crown—resin with high noble metal	$157
D2721	Crown—resin with predominantly base metal	$137
D2722	Crown—resin with noble metal	$143
D2740	Crown—porcelain/ceramic	$153
D2750	Crown—porcelain fused to high noble metal	$288
D2751	Crown—porcelain fused to predominantly base metal	$147
D2752	Crown—porcelain fused to noble metal	$153
D2790	Crown—full cast high noble metal	$281
D2791	Crown—full cast predominantly base metal	$132
D2792	Crown—full cast noble metal	$143
D2930	Prefabricated stainless steel crown— primary tooth	$35
D2931	Prefabricated stainless steel crown—permanent tooth	$35
D2952	Post and core in addition to crown, indirectly fabricated	$58
D2954	Prefabricated post and core in addition to crown	$42
D5110	Complete denture—maxillary	$207
D5120	Complete denture—mandibular	$207
D5130	Immediate denture—maxillary	$217
D5140	Immediate denture—mandibular	$217
D5211	Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)	$127
D5212	Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)	$127
D5213	Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$233

[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.

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ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D5214	Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$215
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$127
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$127
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$233
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$215
D5281	Removable unilateral partial denture—one piece cast metal (including clasps and teeth)	$46
D5410	Adjust complete denture—maxillary[9]	$13
D5411	Adjust complete denture—mandibular[9]	$13
D5421	Adjust partial denture—maxillary[9]	$13
D5422	Adjust partial denture—mandibular[9]	$13
D5730	Reline complete maxillary denture (chairside)[10]	$52
D5731	Reline complete mandibular denture (chairside)[10]	$52
D5740	Reline maxillary partial denture (chairside)[10]	$42
D5741	Reline mandibular partial denture (chairside)[10]	$42
D5750	Reline complete maxillary denture (laboratory)[10]	$76
D5751	Reline complete mandibular denture (laboratory)[10]	$76
D5760	Reline maxillary partial denture (laboratory)[10]	$66
D5761	Reline mandibular partial denture (laboratory)[10]	$66
D6210	Pontic—cast high noble metal	$281
D6211	Pontic—cast predominantly base metal	$132
D6212	Pontic—cast noble metal	$143
D6240	Pontic—porcelain fused to high noble metal	$288
D6241	Pontic—porcelain fused to predominantly base metal	$147
D6242	Pontic—porcelain fused to noble metal	$153
D6250	Pontic—resin with high noble metal	$157
D6251	Pontic—resin with predominantly base metal	$137
D6252	Pontic—resin with noble metal	$143
D6602	Retainer inlay—cast high noble metal, two surfaces[11]	$127
D6603	Retainer inlay—cast high noble metal, three or more surfaces[11]	$137
D6604	Retainer inlay—cast predominantly base metal, two surfaces[11]	$127
D6605	Retainer inlay—cast predominantly base metal, three or more surfaces[11]	$137
D6606	Retainer inlay—cast noble metal, two surfaces[11]	$127
D6607	Retainer inlay—cast noble metal, three or more surfaces[11]	$137
D6720	Retainer crown—resin with high noble metal[11]	$157
D6721	Retainer crown—resin with predominantly base metal[11]	$137
D6722	Retainer crown—resin with noble metal[11]	$143
D6750	Retainer crown—porcelain fused to high noble metal[11]	$288
D6751	Retainer crown—porcelain fused to predominantly base metal[11]	$147
D6752	Retainer crown—porcelain fused to noble metal[11]	$153
D6780	Retainer crown—3/4 cast high noble metal[11]	$147
D6790	Retainer crown—full cast high noble metal[11]	$281
D6791	Retainer crown—full cast predominantly base metal[11]	$137
D6792	Retainer crown—full cast noble metal[11]	$143

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