

**WMI MUTUAL INSURANCE COMPANY**  
**SCHEDULE OF BENEFITS SUMMARY**  
**Arizona Gold 3 Plan**

Eligible services and treatments are covered at the benefit levels shown below, and are subject to all other terms, limitations, and exclusions as set forth in the Policy.

	PPO PROVIDERS	NON-PPO PROVIDERS
<p><b>This plan covers Essential Benefits. "Essential Benefits" means: 1) Ambulatory patient services; 2) Emergency services; 3) Hospitalization; 4) Maternity and newborn care; 5) Mental health and substance abuse, including behavioral health treatment; 6) Prescription drugs; 7) Rehabilitative and habilitative services and devices; 8) Laboratory services; 9) Preventive and wellness services and chronic disease management; and 10) Pediatric services, including oral and vision care. There are no annual or lifetime dollar limits applicable to essential benefits. Any benefit-specific dollar limits referenced in the Schedule of Benefits pertain only to those health care services and supplies that are not essential benefits.</b></p>		
<p><b>DEDUCTIBLE PER CALENDAR YEAR:</b> Deductible does not apply to PPO preventive and wellness services, to medical foods for inherited metabolic disorders, to amino acid-based formulas for eosinophilic disorder, or to any Generic Prescription Drugs.</p>		
<b>Per Individual</b>	\$1,200 for medical services \$200 for Prescription Drugs	
<b>Per Family</b>	\$2,400 for medical services \$400 for Prescription Drugs	
<p><b>MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR:</b> Amounts paid for non-covered care or treatment do not apply towards the Out-of-Pocket amounts.</p>		
<b>Per Individual</b>	\$3,600 for medical and Prescription Drug services	
<b>Per Family</b>	\$7,200 for medical and Prescription Drug services	
<p>The Plan will pay the designated coinsurance percentage of Covered Services until Out-of-Pocket amounts are reached, at which time the Plan will pay 100% of Covered Services during the Calendar Year.</p>		
COVERED SERVICES	PPO PROVIDERS (coinsurance amount paid by the Plan)	NON-PPO PROVIDERS (coinsurance amount paid by the Plan)
<p><b>Note:</b> Any visit maximums listed below are the total for PPO and Non-PPO expenses combined. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between PPO and Non-PPO providers</p>		
<b>Hospital Services</b>		
<ul style="list-style-type: none"> <li><b>Room and Board</b></li> </ul>	80% after Deductible, of the facility's semi-private or private room rate	60% after Deductible, of the facility's semi-private or private room rate
<ul style="list-style-type: none"> <li><b>Intensive Care</b></li> </ul>	80% after Deductible, of the hospital's ICU charge	60% after Deductible, of the hospital's ICU charge
<ul style="list-style-type: none"> <li><b>Skilled Nursing Facility</b></li> </ul>	80% after Deductible, of the	60% after Deductible, of the

	facility's semi-private room rate, limited to 90 days per Calendar Year	facility's semi-private room rate, limited to 90 days per Calendar Year
<b>Outpatient hospital and ambulatory patient services</b>	80% after Deductible	60% after Deductible
<b>Emergency Department Services</b>	80% after Deductible	80% after Deductible, if services are for an Emergency* as defined below, otherwise, 60% after Deductible
<p><b>*Emergency</b> means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.</p>		
<b>Physician Services</b>		
• <b>Inpatient Visits</b>	80% after Deductible	60% after Deductible
• <b>Office Visits/Specialist Visits</b>	80% after Deductible	60% after Deductible
• <b>Surgery</b>	80% after Deductible	60% after Deductible
<b>Home Health Care</b>	80% after Deductible	60% after Deductible
<b>Laboratory tests, diagnostic x-rays, ultrasounds</b>	80% after Deductible	60% after Deductible
<b>Imaging (MRI/MRA, CAT/PET scan, ECT, BEAM)</b>	80% after Deductible	60% after Deductible
<b>Hospice Care</b>	80% after Deductible	60% after Deductible
<b>Ambulance Service</b>	80% after Deductible	60% after Deductible
<b>Jaw Joint/TMJ</b>	80% after Deductible	60% after Deductible
<b>Physical Therapy, Occupational Therapy and Speech Therapy for Rehabilitative purposes</b>	80% after Deductible, limited to 60 visits per Calendar Year on a combined basis	60% after Deductible, limited to 60 visits per Calendar Year on a combined basis
<b>Physical Therapy, Occupational Therapy and Speech Therapy for Habilitative purposes</b>	80% after Deductible, limited to 60 visits per Calendar Year on a combined basis	60% after Deductible, limited to 60 visits per Calendar Year on a combined basis
<b>Durable Medical Equipment</b> (Rented equipment is limited to no more than purchase price)	80% after Deductible	60% after Deductible
<b>Prosthetics</b>	80% after Deductible	60% after Deductible
<b>Spinal Manipulation and Modalities</b>	80% after Deductible	60% after Deductible
<b>Mental Illness Treatment</b>		
• <b>Inpatient</b>	80% after Deductible	60% after Deductible
• <b>Outpatient</b>	80% after Deductible	60% after Deductible
<b>Alcohol/Substance Abuse Treatment</b>		
• <b>Inpatient</b>	80% after Deductible	60% after Deductible
• <b>Outpatient</b>	80% after Deductible	60% after Deductible
<b>Organ Transplants and Joint</b>	80% after Deductible	60% after Deductible

<b>Implants</b>		
<b>Maternity Services</b>	80% after Deductible	60% after Deductible
<b>Circumcisions</b> (must be performed within 30 days of birth)	80% after Deductible, limited to \$150	60% after Deductible, limited to \$150
<b>Sleep studies</b>	80% after Deductible	60% after Deductible
<b>Sleep apnea treatment</b>	80% after Deductible	60% after Deductible
<b>Preventive Care</b>		
<ul style="list-style-type: none"> <li>• <b>U.S. Preventive Services Task Force screening and tests with a rating of A or B</b></li> </ul>	100% (not subject to Deductible)	60% after Deductible
<ul style="list-style-type: none"> <li>• <b>Routine immunizations for children, adolescents and adults<sup>1</sup></b></li> </ul>	100% (not subject to Deductible)	60% after Deductible
<sup>1</sup> Subject to the guidelines as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control		
<ul style="list-style-type: none"> <li>• <b>U.S. Health Resources and Services Administration screening and tests for infants, children, adolescents and women</b></li> </ul>	100% (not subject to Deductible)	60% after Deductible
<ul style="list-style-type: none"> <li>• <b>Routine physical examinations and check-ups, including well baby/child visits<sup>2</sup></b></li> </ul>	100% (not subject to Deductible)	60% after Deductible
<sup>2</sup> Includes office visits, influenza immunizations, gynecological exams, and lab tests required for the examination. Well baby/child visits are covered through 47 months.		
<ul style="list-style-type: none"> <li>• <b>Prostate cancer screening<sup>3</sup></b></li> </ul>	100% (not subject to Deductible)	60% after Deductible
<sup>3</sup> Frequency limits for prostate cancer screening: Annually if you are under age 40 and are at high risk because of (1) family history; (2) African-American race; or (3) previous borderline PSA levels. Annually if you are age 40 or older.		
<ul style="list-style-type: none"> <li>• <b>Colonoscopy screening<sup>4</sup></b></li> </ul>	100% (not subject to Deductible)	60% after Deductible
<sup>4</sup> Beginning at age 50 and subject to the U.S. Preventive Services Task Force and Centers for Disease Control and Prevention guidelines.		
<ul style="list-style-type: none"> <li>• <b>Mammography<sup>5</sup></b></li> </ul>	100% (not subject to Deductible)	60% after Deductible
<sup>5</sup> Frequency limits for mammogram: A baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age. An annual for any woman who is age forty (40) or older. Non-routine mammograms are covered as Medically Necessary elsewhere under general covered services and supplies.		
<b>Other General Covered Services and Supplies</b> (as set forth in the Plan) (with the exception of medical foods and amino-acid	80% after Deductible	60% after Deductible

based formulas)		
<b>Medical foods for inherited metabolic disorder</b>	50% (not subject to Deductible)	50% (not subject to Deductible)
<b>Amino-acid based formula for eosinophilic disorder</b>	75% (not subject to Deductible)	75% (not subject to Deductible)
<b>Pediatric Vision</b> (coverage is only available for Children through the end of the month in which the Child turns 19)		
• <b>Vision screening</b>	80% after Deductible; limited to one test per Calendar Year	60% after Deductible; limited to one test per Calendar Year
• <b>Prescription lenses</b>	80% after Deductible; limited to one pair per Calendar Year	60% after Deductible; limited to one pair per Calendar Year
• <b>Frames</b>	80% after Deductible; limited to one pair per Calendar Year	60% after Deductible; limited to one pair per Calendar Year
• <b>Contacts</b>	80% after Deductible; limited to once per Calendar Year in lieu of lenses and frames	60% after Deductible; limited to once per Calendar Year in lieu of lenses and frames
<b>Coinsurance amount paid by the Plan</b>		
<b>Pediatric Dental</b> (coverage is only available for Children through the end of the month in which the Child turns 19) (refer to the Policy and to the attached listing of ADA codes for a detailed listing of covered services)		
• <b>Diagnostic and Preventive Services</b> (such as exams, x-rays, prophylaxis, topical application of fluoride, and space maintainers)	80% (not subject to Deductible)	
• <b>Restorative, Endodontic and Periodontic Services</b> (such as fillings, oral surgery, root canals, pulpotomy, periodontal scaling, and crowns)	80% after Deductible	
• <b>Prosthodontic Services</b> (such as bridges, dentures, bridge repair, denture repair, and implants)	80% after Deductible	
• <b>Orthodontic Services</b> (orthodontic treatment for cosmetic purposes is not covered)	80% after Deductible	
• <b>General Services</b> (such as emergency palliative treatment, oral or parenteral sedation, and	80% after Deductible	

treatment of post-surgical complications)	
	<b>Coinsurance amount paid by the Plan</b>
<b>Prescription Drugs</b> – coverage is subject to all Policy guidelines. A Generic drug must be used whenever a Generic equivalent is available. If a Brand drug is purchased instead of a Generic equivalent, the Insured is responsible for the price difference.	
• Generic Drugs	80% (not subject to Deductible)*
• Brand Drugs	70% after Deductible*
• Specialty Drugs	70% after Deductible*
*Patient-administered cancer treatment medications, including medications that are orally-administered or self-injected, will be paid at 80% (not subject to Deductible) for generic drugs and at 80% after Deductible for brand and specialty drugs.	

**Pediatric Dental ADA codes and descriptions**

## **General Services**

D9110 Palliative treatment of dental pain – minor procedure  
D9220 Deep sedation/general anesthesia - first 30 minutes  
D9221 Deep sedation/general anesthesia - each additional 15 minutes  
D9241 Intravenous conscious sedation/analgesia - first 30 minutes  
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes  
D9310 Consultation (diagnostic services provided by a dentist or other physician other than the practitioner providing treatment)  
D9610 Therapeutic drug injection, by report  
D9930 Treatment of complications (post-surgical) unusual circumstances, by report

## **Diagnostic Services**

D0120 Periodic oral evaluation - Limited to one exam every 6 months  
D0140 Limited oral evaluation - problem focused - Limited to one exam every 6 months  
D0150 Comprehensive oral evaluation - Limited to one exam every 6 months  
D0180 Comprehensive periodontal evaluation - Limited to one exam every 6 months  
D0210 Intraoral - complete set of radiographic images including bitewings limited to 1 every 60 months  
D0220 Intraoral - periapical first film  
D0230 Intraoral - each additional periapical film  
D0240 Intraoral - occlusal radiographic image  
D0270 Bitewing - single film - One set every 6 months  
D0272 Bitewings - two films - One set every 6 months  
D0274 Bitewings - four films - One set every 6 months  
D0277 Vertical bitewings - 7 to 8 radiographic images – One set every 6 months  
D0330 Panoramic radiographic image - once every 36 months  
D0340 Cephalometric x-ray  
D0350 Oral/Facial photographic images  
D0391 Interpretation of diagnostic image  
D0470 Diagnostic models

## **Preventive Services**

D1120 Prophylaxis - Limited to once every 6 months  
D1206 Topical Fluoride - Varnish - Limited to 2 every 12 months  
D1208 Topical application of fluoride (excluding prophylaxis) - Limited to 2 every 12 months  
D1351 Sealant - per tooth - unrestored permanent molars - 1 time per tooth every 36 months  
D1352 Preventive resin restorations in a moderate to high caries risk patient - permanent tooth - 1 time per tooth every 36 months  
D1510 Space maintainer - fixed - unilateral  
D1515 Space maintainer - fixed - bilateral  
D1520 Space maintainer - removable - unilateral  
D1525 Space maintainer - removable - bilateral  
D1550 Re-cementation of space maintainer

## Restorative Services

D0160 Detailed and extensive oral evaluation – problem focused, by report  
D2140 Amalgam – one surface, primary or permanent  
D2150 Amalgam – two surfaces, primary or permanent  
D2160 Amalgam – three surfaces, primary or permanent  
D2161 Amalgam – four or more surfaces, primary or permanent  
D2330 Resin-based composite – one surface, anterior  
D2331 Resin-based composite – two surfaces, anterior  
D2332 Resin-based composite – three surfaces, anterior  
D2335 Resin-based composite – four or more surfaces or involving incisal angle (anterior)  
D2391 Resin-based composite – one surface, posterior - an alternate benefit may be provided  
D2392 Resin-based composite – two surfaces, posterior - an alternate benefit may be provided  
D2393 Resin-based composite – three surfaces, posterior - an alternate benefit may be provided  
D2510 Inlay - metallic - one surface - An alternate benefit may be provided  
D2520 Inlay - metallic - two surfaces - An alternate benefit may be provided  
D2530 Inlay - metallic - three surfaces - An alternate benefit may be provided  
D2542 Onlay - metallic - two surfaces - Limited to 1 per tooth every 60 months  
D2543 Onlay - metallic - three surfaces - Limited to 1 per tooth every 60 months  
D2544 Onlay - metallic - four or more surfaces - Limited to 1 per tooth every 60 months  
D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months  
D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months  
D2751 Crown - porcelain fused to predominately base metal - Limited to 1 per tooth every 60 months  
D2752 Crown - porcelain fused to noble metal - Limited to 1 per tooth every 60 months  
D2780 Crown - 3/4 cast high noble metal - Limited to 1 per tooth every 60 months  
D2781 Crown - 3/4 cast predominately base metal - Limited to 1 per tooth every 60 months  
D2782 Crown - 3/4 cast noble metal - Limited to 1 per tooth every 60 months  
D2783 Crown - 3/4 porcelain/ceramic - Limited to 1 per tooth every 60 months  
D2790 Crown - full cast high noble metal - Limited to 1 per tooth every 60 months  
D2791 Crown - full cast predominately base metal - Limited to 1 per tooth every 60 months  
D2792 Crown - full cast noble metal - Limited to 1 per tooth every 60 months  
D2794 Crown - titanium - Limited to 1 per tooth every 60 months  
D2950 Core buildup, including any pins - Limited to 1 per tooth every 60 months  
D2954 Prefabricated post and core, in addition to crown - Limited to 1 per tooth every 60 months  
D2980 Crown repair, by report  
D2981 Inlay repair  
D2982 Onlay repair  
D2983 Veneer repair  
D2990 Resin infiltration/smooth surface – limited to 1 every 36 months  
D2910 Re-cement inlay  
D2920 Re-cement crown  
D2929 Pre-fabricated porcelain/ceramic crown – primary tooth - limited to 1 per tooth in 60 months  
D2930 Pre-fabricated stainless steel crown - primary tooth - limited to 1 per tooth in 60 months  
D2931 Pre-fabricated stainless steel crown – permanent tooth - limited to 1 per tooth in 60 months  
D2940 Protective Restoration  
D2951 Pin retention – per tooth, in addition to restoration  
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth  
D7220 Removal of impacted tooth – soft tissue  
D7230 Removal of impacted tooth – partially bony  
D7240 Removal of impacted tooth – completely bony  
D7241 Removal of impacted tooth – completely bony with unusual surgical complications  
D7250 Surgical removal of residual tooth roots (cutting procedure)  
D7251 Coronectomy - intentional partial tooth removal  
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth  
D7280 Surgical access of an unerupted tooth  
D7310 Alveoloplasty in conjunction with extractions – per quadrant oral surgery  
D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant  
D7320 Alveoloplasty not in conjunction with extractions – per quadrant  
D7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant  
D7471 Removal of exostosis  
D7510 Incision and drainage of abscess – intraoral soft tissue  
D7910 Suture of recent small wounds up to 5 cm  
D7953 Bone replacement graft for ridge preservation-per site  
D7971 Excision of pericoronal gingiva

### **Endodontic Services**

D3220 Therapeutic pulpotomy (excluding final restoration)  
D3222 Partial pulpotomy for apexogenesis – permanent teeth with incomplete root development  
D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)  
D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)  
D3310 Anterior root canal (excluding final restoration)  
D3320 Bicuspid root canal (excluding final restoration)  
D3330 Molar root canal (excluding final restoration)  
D3346 Retreatment of previous root canal therapy – anterior  
D3347 Retreatment of previous root canal therapy – bicuspid  
D3348 Retreatment of previous root canal therapy - molar  
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)  
D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)  
D3353 Apexification/recalcification – final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)  
D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) - does not include final restoration  
D3410 Apicoectomy/periradicular surgery – anterior  
D3421 Apicoectomy/periradicular surgery – bicuspid (first root)  
D3425 Apicoectomy/periradicular surgery – molar (first root)  
D3426 Apicoectomy/periradicular surgery (each additional root)  
D3450 Root amputation – per root  
D3920 Hemisection (including any root removal) – not including root canal therapy



## **Periodontal Services**

- D4341 Periodontal scaling and root planning - four or more teeth per quadrant - Limited to 1 every 24 months
- D4342 Periodontal scaling and root planning - one to three teeth per quadrant - Limited to 1 every 24 months
- D4910 Periodontal maintenance - 4 in 12 months combined with prophylaxis after the completion of active periodontal therapy
- D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant - Limited to 1 every 36 months
- D4211 Gingivectomy or gingivoplasty – one to three teeth, per quadrant
- D4212 Gingivectomy or gingivoplasty - with restorative procedures, per tooth
- D4240 Gingival flap procedure, including root planning, four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
- D4241 Gingival flap procedure, including root planning, one to three teeth per quadrant – Limited to 1 every 36 months
- D4249 Clinical crown lengthening – hard tissue
- D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
- D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
- D4263 Bone replacement graft - first site in quadrant – limited to 1 every 36 months
- D4270 Pedicle soft tissue graft procedure
- D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
- D4275 Soft tissue allograft – limited to 1 every 36 months
- D4277 Free soft tissue graft procedure (including donor site surgery) - first tooth or edentulous tooth position in graft
- D4278 Free soft tissue graft procedure (including donor site surgery) – each additional tooth or edentulous tooth position in graft
- D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis - Limited to 1 per lifetime
- D7921 Collect – apply autologous product – limited to 1 every 36 months

## **Prosthodontic Services**

- D5110 Complete denture – maxillary – limited to 1 every 60 months
- D5120 Complete denture - mandibular – limited to 1 every 60 months
- D5130 Immediate denture – maxillary – limited to 1 every 60 months
- D5140 Immediate denture - mandibular - limited to 1 every 60 months
- D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) - limited to 1 every 60 months
- D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) - limited to 1 every 60 months
- D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) - limited to 1 every 60 months

D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) - limited to 1 every 60 months

D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) - limited to 1 every 60 months

D5410 Adjust complete denture – maxillary

D5411 Adjust complete denture – mandibular

D5421 Adjust partial denture – maxillary

D5422 Adjust partial denture – mandibular

D5510 Repair broken complete denture base

D5520 Replace missing or broken teeth – complete denture (each tooth)

D5610 Repair resin denture base

D5620 Repair cast framework

D5630 Repair or replace broken clasp

D5640 Replace broken teeth – per tooth

D5650 Add tooth to existing partial denture

D5660 Add clasp to existing partial denture

D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5730 Reline complete maxillary denture (chairside) - Limited to 1 in a 36-month period 6 months after the initial installation

D5731 Reline complete mandibular denture (chairside) - Limited to 1 in a 36-month period 6 months after the initial installation

D5740 Reline maxillary partial denture (chairside) - Limited to 1 in a 36-month period 6 months after the initial installation

D5741 Reline mandibular partial denture (chairside) - Limited to 1 in a 36-month period 6 months after the initial installation

D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

D5761 Reline mandibular partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

D5850 Tissue conditioning (maxillary)

D5851 Tissue conditioning (mandibular)

D6010 Endosteal Implant – surgical placement – limited to 1 every 60 months

D6012 Surgical Placement of Interim Implant Body – limited to 1 every 60 months

D6040 Eposteal Implant – limited to 1 every 60 months

D6050 Transosteal Implant, including hardware – limited to 1 every 60 months

D6053 Implant supported complete denture

D6054 Implant supported partial denture

D6055 Connecting bar – implant or abutment supported – limited to 1 every 60 months

D6056 Prefabricated Abutment - includes modification and placement – limited to 1 every 60 months  
D6057 Custom abutment - limited to 1 every 60 months  
D6058 Abutment supported porcelain ceramic crown – limited to 1 every 60 months  
D6059 Abutment supported porcelain fused to metal crown - high noble metal - limited to 1 every 60 months  
D6060 Abutment supported porcelain fused to metal crown - predominately base metal - limited to 1 every 60 months  
D6061 Abutment supported porcelain fused to metal crown - noble metal - limited to 1 every 60 months  
D6062 Abutment supported cast metal crown - high noble metal - limited to 1 every 60 months  
D6063 Abutment supported cast metal crown - predominately base metal – limited to 1 every 60 months  
D6064 Abutment supported cast noble metal crown - noble metal – limited to 1 every 60 months  
D6065 Implant supported porcelain/ceramic crown – limited to 1 every 60 months  
D6066 Implant supported porcelain fused to high metal crown - titanium, titanium alloy, high noble metal – limited to 1 every 60 months  
D6067 Implant supported metal crown - titanium, titanium alloy, high noble metal – limited to 1 every 60 months  
D6068 Abutment supported retainer for porcelain/ceramic FPD – limited to 1 every 60 months  
D6069 Abutment supported retainer for porcelain fused to metal FPD - high noble metal – limited to 1 every 60 months  
D6070 Abutment supported retainer for porcelain fused to metal FPD - predominately base metal – limited to 1 every 60 months  
D6071 Abutment supported retainer for porcelain fused to metal FPD - noble metal – limited to 1 every 60 months  
D6072 Abutment supported retainer for cast metal FPD - high noble metal – limited to 1 every 60 months  
D6073 Abutment supported retainer for cast metal FPD - predominately base metal - limited to 1 every 60 months  
D6074 Abutment supported retainer for cast metal FPD - noble metal - limited to 1 every 60 months  
D6075 Implant supported retainer for ceramic FPD – limited to 1 every 60 months  
D6076 Implant supported retainer for porcelain fused to metal FPD - titanium, titanium alloy, or high noble metal - limited to 1 every 60 months  
D6077 Implant supported retainer for cast metal FPD - titanium, titanium alloy, or high noble metal – limited to 1 every 60 months  
D6078 Implant/abutment supported fixed partial denture for completely edentulous arch – limited to 1 every 60 months  
D6079 Implant/abutment supported fixed partial denture for partially edentulous arch – limited to 1 every 60 months  
D6080 Implant Maintenance Procedures – limited to 1 every 60 months  
D6090 Repair Implant Prosthesis – limited to 1 every 60 months  
D6091 Replacement of Semi-Precision or Precision Attachment – limited to 1 every 60 months  
D6095 Repair Implant Abutment – limited to 1 every 60 months  
D6100 Implant Removal – limited to 1 every 60 months  
D6101 Debridement periimplant defect, covered if implants are covered – limited to 1 every 60 months  
D6102 Debridement and osseous periimplant defect, covered if implants are covered – limited to 1 every 60 months  
D6103 Bone graft periimplant defect, covered if implants are covered

D6104 Bone graft implant replacement, covered if implants are covered  
D6190 Implant Index – limited to 1 every 60 months  
D6210 Pontic - cast high noble metal - limited to 1 every 60 months  
D6211 Pontic - cast predominately base metal - limited to 1 every 60 months  
D6212 Pontic - cast noble metal - limited to 1 every 60 months  
D6214 Pontic - titanium - limited to 1 every 60 months  
D6240 Pontic - porcelain fused to high noble metal - limited to 1 every 60 month  
D6241 Pontic - porcelain fused to predominately base metal - limited to 1 every 60 months  
D6242 Pontic - porcelain fused to noble metal - limited to 1 every 60 months  
D6245 Pontic - porcelain/ceramic - limited to 1 every 60 months  
D6519 Inlay/onlay – porcelain/ceramic – limited to 1 every 60 months  
D6520 Inlay – metallic – two surfaces – limited to 1 every 60 months  
D6530 Inlay – metallic – three or more surfaces – limited to 1 every 60 months  
D6543 Onlay – metallic – three surfaces – limited to 1 every 60 months  
D6544 Onlay – metallic – four or more surfaces – limited to 1 every 60 months  
D6545 Retainer - cast metal for resin bonded fixed prosthesis - limited to 1 every 60 months  
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis - limited to 1 every 60 months  
D6740 Crown - porcelain/ceramic – limited to 1 every 60 months  
D6750 Crown - porcelain fused to high noble metal - limited to 1 every 60 months  
D6751 Crown - porcelain fused to predominately base metal – limited to 1 every 60 months  
D6752 Crown - porcelain fused to noble metal - limited to 1 every 60 months  
D6780 Crown - 3/4 cast high noble metal - limited to 1 every 60 months  
D6781 Crown - 3/4 cast predominately base metal - limited to 1 every 60 months  
D6782 Crown - 3/4 cast noble metal – limited to 1 every 60 months  
D6783 Crown - 3/4 porcelain/ceramic – limited to 1 every 60 months  
D6790 Crown - full cast high noble metal - limited to 1 every 60 months  
D6791 Crown - full cast predominately base metal - limited to 1 every 60 months  
D6792 Crown - full cast noble metal - limited to 1 every 60 months D6794 Crown - Titanium - limited to 1 every 60 months  
D6930 Re-cement fixed partial denture  
D6980 Fixed partial denture repair, by report  
D9120 Fixed partial denture sectioning  
D9940 Occlusal guard, by report - 1 in 12 months for patients 13 and older

### **Orthodontic Services**

D8010 Limited orthodontic treatment of the primary dentition  
D8020 Limited orthodontic treatment of the transitional dentition  
D8030 Limited orthodontic treatment of the adolescent dentition  
D8050 Interceptive orthodontic treatment of the primary dentition  
D8060 Interceptive orthodontic treatment of the transitional dentition  
D8070 Comprehensive orthodontic treatment of the transitional dentition  
D8080 Comprehensive orthodontic treatment of the adolescent dentition  
D8090 Comprehensive orthodontic treatment of the adult dentition  
D8210 Removable appliance therapy  
D8220 Fixed appliance therapy  
D8660 Pre-orthodontic treatment visit

D8670 Periodic orthodontic treatment visit (as part of contract)

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))