2024

Supplemental Dental Coverage

KelseyCare Advantage (HMO) INSERT TO 2024 EVIDENCE OF COVERAGE
for the Classic plan (H0332-002) Chapter 4, Section 2.2, Extra "optional supplemental" benefits you can purchase Dental Optional Supplemental Benefits

Our plan offers some extra benefits that are not covered by Original Medicare and are not included in your benefits package as a plan member. These extra benefits are called "Optional Supplemental Benefits". If you want these optional supplemental benefits, you must sign up for them, and you will have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

Adding Optional Supplemental Benefits to your plan
You must be enrolled in the KelseyCare Advantage Classic (HMO) plan and have a plan ID number in order to enroll into our Optional Supplemental Benefit Plan. Enrolling into our Optional Supplemental Benefit Plan is optional and does require a monthly premium of $32.80.

There is no waiting period to access services.

Enrolling in Optional Supplemental Benefits
To enroll in the Optional Supplemental Benefit Plan, call KelseyCare Advantage Concierge team at 713-442-2273 to request an application. Enrollment into the Optional Supplemental Benefit Plan may be requested at the time of enrollment into KelseyCare Advantage Classic plan or any time after membership in the current benefit year. You can enroll in Optional Supplemental Benefits by providing a completed supplemental benefits enrollment application during one of the following times: Between October 15 and December 7 of each year, for coverage to become effective January 1 of the following year or anytime during the current benefit year for coverage to begin the first day of the following month.

Disenrolling from Optional Supplement Benefit Plan
If you wish to disenroll from our Optional Supplemental Benefit Plan, you may call Customer Service at 713-442-2273.

Optional Supplemental Benefit Plan disenrollment requests received by the last day of the month will be effective the first day of the following month. Members will be responsible for the Optional Supplemental Benefit Plan premium payment for the following month if the disenrollment request is received after the last day of the current month. Disenrollment from our Optional Supplemental Benefit Plan will not result in disenrollment from your health plan.

Your first month's premium for the Optional Supplemental Benefit Plan will be billed to you. If you wish to change the way you pay your premium you will need to contact KelseyCare Advantage Concierge team at 713-442-2273 after you become a member.

Non-payment of premiums for our Optional Supplemental Benefit Plan will not result in disenrollment from your health plan. However you will lose your Optional Supplemental Benefit Plan and return to the basic benefit plan.

If you disenroll from your KelseyCare Advantage Plan, you will be automatically disenrolled from your Optional Supplemental Benefit Plan.

If you have a covered procedure in progress at the time of your termination of your Optional Supplemental Benefit Plan, your provider will complete the procedure. If we cancel your network provider office's contract, or if your network provider office cancels their contract with us, it will be our responsibility to see that you receive your benefits at another network provider's office.

Reenrollment in Optional Supplemental Benefits
If you have ceased premium payment or have requested to terminate your Optional Supplemental Benefits, you will not be able to return to the Optional Supplemental Benefit plan until the next calendar year.

Refund of Premium
Members enrolled in our Optional Supplemental Benefit Plan have a monthly plan premium and are entitled to a refund for any overpayments of plan premiums made during the course of the year or at the time of disenrollment. Overpayments of Optional Supplemental Benefits Plan premiums will be refunded upon request or disenrollment. We will refund any overpayments within 30 business days of notification. We may apply your overpayment of Optional Supplemental benefit plan premiums to your monthly health plan premiums, if any.

The Optional Supplemental Benefit Plan coverage described below is only offered to members who are enrolled in the Classic plan (HMO) If you are not currently enrolled in the Optional Supplemental Benefit Plan and you would like to have the additional coverage, you can call KelseyCare Advantage for more information.

Subject to the terms, conditions, limitations, and exclusions specified in our Optional Supplemental Dental Insert you must receive covered dental services from participating dental providers. See the section below "Limitations and Exclusions" for dental exclusions and limitations. Services received from non-participating dentists are not covered under this plan.

KS Plan Administrators, LLC has partnered with the Dental Administrator (FCL Dental) to provide optional supplemental dental services through participating dental providers.

FCL Dental

The FCL Dental Optional Supplemental Benefit package covers beyond that which is required by Medicare. This plan has a monthly plan premium of $32.80. This is in addition to any plan premium you may have for your Medicare Part B or Medicare Advantage plan. These Optional Supplemental Benefits include the major dental services listed in the grid below. The Optional Supplemental Benefits cannot be combined with any other dental benefits that may be offered on your plan or any other plan offered through an employer or union.

If you have additional questions, please call FCL Dental Customer Service at 1-866-535-8343.

How to Choose a Network Dentist

There are several ways to find a network dentist. You may visit FCLDental.com/provider-search and search by location or provider name. You may also call FCL Dental Customer Service at 1-866-535-8343 if you need a Provider Directory sent to you or need help locating a participating dentist. The network dentist will provide most services either directly or through a licensed dental hygienist. Services provided by a network specialized dentist do not require a referral from your standard network dentist, but we encourage you to consult him/her first. You must use a network dentist for services to be covered.

After you have chosen a network dentist, just call and make your appointment. Tell the dental office which health plan you belong to and give your KelseyCare Advantage member ID card at the appointment.

Purchasing this Optional Supplemental Benefit Plan does not guarantee that you will get any given dental services from any particular dentist. If you are using a network dentist, always confirm the dentist's participation in the network prior to receiving care. If we cancel a network dentist's contract, or if a network dentist cancels his/ her contract with us, you have the freedom to choose another network dentist for your care.

Only the dental services listed under the FCL Dental Coverage Table below will be covered under the Optional Supplemental Benefit plan. You must pay all fees for non-covered services to the dentist at the time of services. **It is your responsibility to understand your dental coverage and use your dental benefits appropriately.**

Network dentists may ask you to sign an informed consent document detailing the risks, dental benefits, costs and alternatives to all recommended treatments. In the performance of recommended dental treatments, outcomes may not always be accurately predicted. Sometimes, a specific network dentist must make a judgment about continuing care that is in your best interest. Following the procedure, it is the obligation of the network dentist to explain in detail why these changes in treatment were required and to explain the differences in costs to you, if any.

Making an Appointment
Once you have selected a network dentist, you can make an appointment by directly calling that dental office. If you have any questions regarding office locations, office hours, or emergency hours, please call your selected Dental Office or call FCL Dental Customer Service. For information on other network dental providers in your area, please contact FCL Customer Service or visit the website listed above.

FCL Dental Plan Covered Dental Services
Covered dental services are subject to the limitations and exclusions described in this Optional Supplemental Benefit Plan Insert. Dental Services described in this section are Covered Dental Services when such services are:

- ☐ Provided by or under the direction of a licensed dentist or other appropriate provider as specifically described; and
- ☐ Not excluded as described in this Optional Supplemental Benefit Plan Insert

FCL Dental Coverage Table:

You may receive the following dental services:

Benefits received out-of-network are not covered, you will be responsible for all costs.

Coverage Description

Monthly Premium Amount	$32.80
Annual Deductible	$25
Annual Maximum (After the annual maximum is exhausted, any remaining charges are your responsibility)	$3,000

Percentage of Covered Dental Expenses Payable: Covered charges in excess of the Annual Deductible will be paid the KelseyCare Advantage dental plan up to the $3,000 Annual Maximum at the Coinsurance Rates below:

Service Type	Service Description	Coverage Rate	Amount You Pay
Type II	Basic Services	80%	20% of the cost
Type III	Major Services	50%	50% of the cost

SEE PROCEDURE CODE LIST AT THE END OF THIS SECTION

LIMITATIONS AND EXCLUSION. Covered Expenses will not include, and no benefits will be payable for, the following:

1. For any treatment which is for cosmetic purposes or to correct congenital malformations, except for medically necessary care and treatment of congenital cleft lip and palate.
2. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items, unless required because of an accidental bodily injury sustained while the Insured is covered. Replacement is not covered if the item can be repaired.
3. For initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of natural teeth during the same period of continuous coverage. But the extraction of a third molar (wisdom tooth) will not qualify the item for payment. Any such appliances or fixed bridge must include the replacement of the extracted tooth or teeth. Coverage does not include the part of the cost that applies specifically to replacement of teeth extracted prior to the period of coverage.
4. For addition of teeth to an existing prosthetic appliance or fixed bridge unless for replacement of natural teeth extracted during the same period of continuous coverage.
5. For any expense incurred or procedure begun before the Insured's current period of continuous coverage.
6. For any expense incurred or procedure begun after the Insured's insurance under this section terminates, except for a prosthetic appliance, fixed bridge, crown, or inlay or onlay restoration for which both (a) the procedure begins before insurance ends and (b) the item's final replacement is within 90 days after insurance ends.
7. To duplicate appliances or replace lost or stolen appliances.
8. For appliances, restorations, or procedures to:
   a. alter vertical dimension;
   b. restore or maintain occlusion;
   c. splint or replace tooth structure lost as a result of abrasion or attrition; or
   d. treat jaw fractures or disturbances of the temporomandibular joint.
9. For education or training in, and supplies for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
10. For broken appointments or the completion of claim forms.
11. For orthodontia service or for any services associated with orthodontic therapy when this optional coverage is not elected, and the premium is not paid.
12. For sealants which are:
    a. not applied to a permanent molar;
    b. applied before age 6 or after attaining age 16; or
    c. reapplied to molar within three years from the date of a previous sealant application.

13. For subgingival curettage or root planning (procedure number 4220 and 4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.
14. Because of an Insured's injury arising out of, or in the course of, work for wage or profit.
15. For an Insured's sickness, injury or condition for which he or she is eligible for benefits under any Workers Compensation Act or similar law.
16. For changes for which the Insured is not liable or which would not have been made had no insurance been in force.
17. For services which are not recommended by a dentist, not required for necessary care and treatment, or do not have a reasonable favorable prognosis.
18. Because of war or any act of war, declared or not, or while on full-time active duty in the armed forces of any country.
19. To an Insured if payment is not legal where the Insured is living when expensed are incurred.
20. For any services related to: equilibration, bite registration or bite analysis.
21. For crowns for the purpose of periodontal splinting.
22. For charges for: any implants; overdentures; precision or semi-precision attachments and associated endodontic treatment; other customized attachments; or specialized prosthodontic techniques or characterizations.
23. For charges for myofunctional therapy. Orthognathic surgery or athletic mouthguards.
24. Services or supplies provided by a family member or a member of the Insured's household.

Predetermination of Benefits: As a service to protect the Insured, the FCL Dental plan will provide predetermination of benefits, upon request by your participating dentist, for recommended treatment plans that exceed $300. This predetermination of benefits explains which of the recommended procedures will be covered and at what amount. A predetermination makes it easier to understand your coverage. Members should submit the treatment plan to KelseyCare Advantage for review and predetermination of benefits before the service begins.

Submission of Dental Claims:

ATTN: Claims Department 101 Parklane Blvd, Suite 301, Sugar Land, TX 77478

Verification of Claims:
1-877-493-6282 (toll free)

Organization Determination, Appeal and Grievance Procedures
If you wish to file an appeal or grievance, please see the Appeals and Grievance process outlined in your Plan's Evidence of Coverage.

Dental Records
We shall have access to your dental and treatment records to determine benefits, process claims, utilization review, quality assurance, financial audit, or for any other purpose reasonably related to covered dental services. You shall complete and submit to us such additional consents, releases and other documents as may be requested in order to determine or provide benefits. We reserve the right to reject or suspend a claim based on lack of supporting dental information or records.

PROCEDURE CODES

Code	Procedure Description	Frequency	Procedure Type
Restorative (D2510-D2664 One Inlay/Onlay per tooth per 60 months)			
D2140	Amalgam - one surface, primary or permanent		Type II
D2150	Amalgam - two surfaces, primary or permanent		Type II
D2160	Amalgam - three surfaces, primary or permanent		Type II
D2161	Amalgam - four or more surfaces, primary or permanent		Type II
D2330	Resin-based composite - one surface - anterior		Type II
D2331	Resin-based composite - two surfaces - anterior		Type II
D2332	Resin-based composite - three surfaces - anterior		Type II
D2335	Resin-based composite - four or more surfaces- anterior		Type II
D2390	Resin-based composite crown, anterior		Type II
D2391	Resin based composite - one surface, posterior		Type II
D2392	Resin based composite -two surfaces, posterior		Type II
D2393	Resin based composite - three or more surfaces, posterior		Type II
D2394	Resin-based composite - four or more surfaces - posterior		Type II
D2510	Inlay-metallic - one surface	1/60 months	Type III
D2520	Inlay-metallic - two surfaces	1/60 months	Type III
D2530	Inlay-metallic - three or more surfaces	1/60 months	Type III
D2543	Onlay-metallic - three surfaces	1/60 months	Type III
D2544	Onlay-metallic - four or more surfaces	1/60 months	Type III
D2610	Inlay-porcelain/ceramic - one surface	1/60 months	Type III
D2620	Inlay-porcelain/ceramic - two surfaces	1/60 months	Type III
D2630	Inlay-porcelain/ceramic - three or more surfaces	1/60 months	Type III
D2642	Onlay - porcelain/ceramic - two surfaces	1/60 months	Type III
D2643	Onlay - porcelain/ceramic - three surfaces	1/60 months	Type III
D2644	Onlay - porcelain/ceramic - four or more surfaces	1/60 months	Type III
D2650	Inlay - resin based composite - one surface	1/60 months	Type III
D2651	Inlay - resin based composite - two surfaces	1/60 months	Type III
D2652	Inlay - resin based composite - three or more surfaces	1/60 months	Type III
D2662	Onlay - resin based composite - two surfaces	1/60 months	Type III
D2663	Onlay - resin based composite - three surfaces	1/60 months	Type III
D2664	Onlay - resin based composite - four or more surfaces	1/60 months	Type III

Restorative (Crowns - Single Restorations) (One Crown per tooth per 60 months)			
D2710	Crown - resin based composite (indirect)	1/60 months	Type III
D2720	Crown - resin with high noble metal	1/60 months	Type III
D2721	Crown - resin with predominantly base metal	1/60 months	Type III
D2722	Crown - resin with noble metal	1/60 months	Type III
D2740	Crown - porcelain/ceramic substrate	1/60 months	Type III
D2750	Crown - porcelain fused to high noble metal	1/60 months	Type III
D2751	Crown - porcelain fused to predominantly base metal	1/60 months	Type III
D2752	Crown - porcelain fused to noble metal	1/60 months	Type III
D2790	Crown - full cast high noble metal	1/60 months	Type III
D2791	Crown - full cast predominantly base metal	1/60 months	Type III
D2792	Crown - full cast noble metal	1/60 months	Type III
D2920	Recement crown	1/60 months	Type III
D2930	Prefabricated stainless steel crown- primary tooth	1/60 months	Type III
D2931	Prefabricated stainless steel crown- permanent tooth	1/60 months	Type III
D2932	Prefabricated resin crown	1/60 months	Type III
D2933	Prefabricated stainless steel crown with resin window	1/60 months	Type III
D2950	Core build-up, including any pins when required	1/60 months	Type III
D2951	Pin retention-per tooth, in addition to restoration	1/60 months	Type III
D2952	Post and core in addition to crown, indirectly fabricated	1/60 months	Type III
D2954	Prefabricated post and core in addition to crown	1/60 months	Type III
D2955	Post removal	1/60 months	Type III
Endodontics (Root Canal Therapy) (D3110 or D3120, one code per 60 months, D3310, D3330, or			
D3110	Pulp cap - direct (excluding final restoration)	1 per Tooth	Type III
D3120	Pulp cap - indirect (excluding final restoration)	1 per Tooth	Type III
D3220	Therapeutic pulpotomy (excluding final restoration)	1 per Tooth	Type III
D3230	Pulpal therapy (resorbable filling) - anterior primary	1 per Tooth	Type III
D3240	Pulpal therapy (resorbable filling) - posterior primary	1 per Tooth	Type III
D3310	Endodontic therapy, anterior (excluding final restoration)	1 per Tooth	Type III
D3320	Endodontic therapy, bicuspid (excluding final restoration)	1 per Tooth	Type III
D3330	Endodontic therapy, molar (excluding final restoration)	1 per Tooth	Type III
D3351	Apexification/recalcification - initial visit	1 per Tooth	Type III
D3352	Apexification/recalcification - interim medication replacement	1 per Tooth	Type III
D3353	Apexification/recalcification - final visit	1 per Tooth	Type III
D3410	Apicoectomy - anterior	1 per Tooth	Type III
D3421	Apicoectomy - bicuspid (first root)	1 per Tooth	Type III
D3425	Apicoectomy - molar (first root)	1 per Tooth	Type III
D3426	Apicoectomy (each additional root)	1 per Tooth	Type III
D3430	Retrograde filling- per root	1 per Tooth	Type III
D3450	Root amputation- per root	1 per Tooth	Type III
D3460	Endodontic end osseous implant	1 per Tooth	Type III
D3470	Intentional re-implantation (including necessary splinting)	1 per Tooth	Type III

Periodontics (Chart review required for all Periodontics codes)			
D4210	Gingivectomy or gingivoplasty-four or more teeth/quadrant	4 Quad /36	Type III
D4211	Gingivectomy or gingivoplasty-one to three teeth/quadrant	4 Quad /36	Type III
D4240	Gingival flap incl. root planning-four or more teeth/quadrant	1 per tooth	Type III
D4249	Clinical crown lengthening-hard tissue	1/60 months	Type III
D4260	Osseous surgery - four or more teeth/quadrant	4 Quad /36	Type III
D4261	Osseous surgery - one to three teeth/quadrant	4 Quad /36	Type III
D4263	Bone replacement graft - first site in quadrant	1/60 months	Type III
D4264	Bone replacement graft - each additional site in quadrant	1/60 months	Type III
D4266	Guided tissue regeneration - resorbable barrier	1/60 months	Type III
D4267	Guided tissue regeneration - not resorbable barrier	1/60 months	Type III
D4270	Pedicle soft tissue graft procedure	1/60 months	Type III
D4273	Sub epithelial connective tissue graft, per tooth	1/60 months	Type III
D4274	Distal or proximal wedge procedure	1/60 months	Type III
D4277	Free soft tissue graft procedure, including donor site surgery, first tooth or edentulous tooth position in graft	1/60 months	Type III
D4341	Periodontal scaling & root planning four or more teeth per/quad	4 Quad /24	Type III
D4342	Periodontal scaling & root planning one to three teeth per/quad	4 Quad /24	Type III
D4355	Full mouth debridement	1/12 months	Type III
D4910	Periodontal maintenance	1/6 months	Type III
Prosthodontics (Removable) (D5110, D5130, D5211, or D5213 one code per 60 months, D5120, D5140, D5212, or D5214 one code per 60 months)			
D5110	Complete dentures-maxillary	1/60 months	Type III
D5120	Complete dentures-mandibular	1/60 months	Type III
D5130	Immediate denture- maxillary	1/60 months	Type III
D5140	Immediate denture- mandibular	1/60 months	Type III
D5211	Maxillary partial denture- resin base	1/60 months	Type III
D5212	Mandibular partial denture- resin base	1/60 months	Type III
D5213	Maxillary partial denture- metal framework/resin base	1/60 months	Type III
D5214	Mandibular partial denture- metal framework/resin base	1/60 months	Type III
D5281	Removable unilateral partial denture - one piece cast metal	1/60 months	Type III
D5730	Reline complete maxillary denture (chairside)		Type III
D5731	Reline complete mandibular denture (chairside)		Type III
D5740	Reline maxillary partial denture (chairside)		Type III
D5741	Reline mandibular partial denture (chairside)		Type III
D5750	Reline complete maxillary denture (lab)		Type III
D5751	Reline complete mandibular denture (lab)		Type III
D5760	Reline maxillary partial denture (lab)		Type III
D5761	Reline mandibular partial denture (lab)		Type III
D5863	Overdenture-complete maxillary	1/60 months	Type III
D5864	Overdenture- partial maxillary	1/60 months	Type III
D5865	Overdenture-complete mandibular	1/60 months	Type III
D5866	Overdenture- partial mandibular	1/60 months	Type III

Implant Services			
D6010	Surgical placement of implant body: endosteal implant	1/120	Type III
D6040	Surgical placement: eposteal implant	1/120	Type III
D6050	Surgical placement: transosteal implant	1/120	Type III
D6058	Abutment supported porcelain/ceramic crown	1/120	Type III
D6059	Abutment supported porcelain fused to metal crown (high noble	1/120	Type III
D6060	Abutment supported porcelain fused to metal crown (predominantly	1/120	Type III
D6061	Abutment supported porcelain fused to metal crown (noble metal)	1/120	Type III
D6062	Abutment supported cast metal crown (high noble metal)	1/120	Type III
D6063	Abutment supported cast metal crown (predominantly base metal)	1/120	Type III
D6064	Abutment supported cast metal crown (noble metal)	1/120	Type III
D6065	Implant supported porcelain/ceramic	1/120	Type III
D6066	Implant supported porcelain fused to metal crown(titanium, titanium	1/120	Type III
D6067	Implant supported metal crown (titanium, titanium alloy, high noble	1/120	Type III
D6068	Abutment supported retainer for porcelain/ceramic FPD	1/120	Type III
D6069	Abutment supported retainer for porcelain fused to metal FPD-high	1/120	Type III
D6070	Abutment supported retainer for porcelain fused to metal FPD	1/120	Type III
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble	1/120	Type III
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	1/120	Type III
D6073	Abutment supported retainer for cast metal FPD (predominantly	1/120	Type III
D6074	Abutment supported retainer for cast metal FPD (noble metal)	1/120	Type III
D6075	Implant supported retainer for ceramic FPD	1/120	Type III
D6076	Implant supported retainer for porcelain fused to metal fpd (titanium,	1/120	Type III
D6077	Implant supported retainer for cast metal fpd (titanium, titanium alloy,	1/120	Type III
D6094	Abutment supported crown – (titanium)	1/120	Type III
D6100	Implant removal, by report	1/120	Type III
D6194	Abutment supported retainer crown for fpd (titanium)	1/60 months	Type III
D6205	Pontic, indirect resin based composite.	1/60 months	Type III
D6210	Pontic - cast high noble metal	1/60 months	Type III
D6211	Pontic - cast predominantly base metal	1/60 months	Type III
D6212	Pontic - cast noble metal	1/60 months	Type III
D6214	Pontic, titanium	1/60 months	Type III
D6240	Pontic - porcelain fused to high noble metal	1/60 months	Type III
D6241	Pontic - porcelain fused to predominantly base metal	1/60 months	Type III
D6242	Pontic - porcelain fused to noble metal	1/60 months	Type III
D6245	Pontic, porcelain/ceramic	1/60 months	Type III
D6250	Pontic - resin with high noble metal	1/60 months	Type III
D6251	Pontic - resin with predominantly base metal	1/60 months	Type III
D6252	Pontic - resin with noble metal	1/60 months	Type III
D6545	Retainer - cast metal for resin bonded fixed prosthesis	1/60 months	Type III

Prosthodontics (Fixed) (D6720-D6792 One crown code per tooth per 60 months)			
D6608	Onlay - porcelain/ceramic - two surfaces	1/60 months	Type III
D6609	Onlay - porcelain/ceramic - three or more surfaces	1/60 months	Type III
D6610	Onlay - cast high noble metal - two surfaces	1/60 months	Type III
D6611	Onlay - cast high noble metal - three or more surfaces	1/60 months	Type III
D6612	Onlay - cast predominantly base metal - two surfaces	1/60 months	Type III
D6613	Onlay - cast predominantly base metal - three+ surfaces	1/60 months	Type III
D6614	Onlay - cast noble metal - two surfaces	1/60 months	Type III
D6615	Onlay - cast noble metal - three or more surfaces	1/60 months	Type III
D6634	Onlay, titanium	1/60 months	Type III
D6720	Crown - resin with high noble metal	1/60 months	Type III
D6721	Crown - resin with predominantly base metal	1/60 months	Type III
D6722	Crown - resin with noble metal	1/60 months	Type III
D6740	Crown - porcelain/ceramic	1/60 months	Type III
D6750	Crown - porcelain fused to high noble metal	1/60 months	Type III
D6751	Crown - porcelain fused to predominantly base metal	1/60 months	Type III
D6752	Crown - porcelain fused to noble metal	1/60 months	Type III
D6780	Crown - 3/4 cast high noble metal	1/60 months	Type III
D6790	Crown - full cast high noble metal	1/60 months	Type III
D6791	Crown - full cast predominantly base metal	1/60 months	Type III
D6792	Crown - full cast noble metal	1/60 months	Type III
D6940	Stress breaker	1/60 months	Type III
Oral Surgery			
D7111	Extraction-coronal remnants - deciduous tooth	1 per tooth	Type III
D7140	Extraction-erupted tooth or exposed root	1 per tooth	Type III
D7210	Surgical removal of erupted tooth	1 per tooth	Type III
D7220	Removal of impacted tooth-soft tissue	1 per tooth	Type III
D7230	Removal of impacted tooth-partial bony	1 per tooth	Type III
D7240	Removal of impacted tooth-completely bony	1 per tooth	Type III
D7241	Removal of impacted tooth-completely bony-complications	1 per tooth	Type III
D7250	Surgical removal of residual roots	1 per tooth	Type III
D7272	Tooth transplantation	1 per tooth	Type III
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	1 per tooth	Type III
D7290	Surgical repositioning of teeth	1 per tooth	Type III
D7291	Transseptal fiberotomy	1 per tooth	Type III
D7310	Alveoloplasty in conjunction with extractions/four + per quad	4 quad per	Type III
D7311	Alveoloplasty in conjunction with extractions, one to three teeth or	4 quad per	Type III
D7320	Alveoloplasty not in conjunction with extractions/four + per quad	4 quad per	Type III
D7321	Alveoloplasty not in conjunction with extractions, one to three teeth	4 quad per	Type III
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	4 quad per	Type III
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts)	4 quad per	Type III
D7961	Buccal/labial frenectomy (Frenulectomy)	1 per tooth	Type III
D7962	Lingual frenectomy (Frenulectomy)	1 per tooth per Lifetime	Type III

Oral Surgery, continued			
D7970	Excision of hyperplastic tissue - per arch	1 per tooth per Lifetime	Type III
D7971	Excision of pericoronal gingiva	1 per tooth per Lifetime	Type III