



# ADN BENEFIT SCHEDULE

## SCHEDULE OF DENTAL SERVICES

All procedures listed as performed by a General Practitioner.

These benefits are available to the member, spouse, and unmarried dependents up to the age of 19, or if the children are unmarried, full-time students and dependent upon the member for support, to the age of 26.

<u>COVEREDSERVICES</u>	<u>CO-PAYMENT</u>	<u>COVEREDSERVICES</u>	<u>CO-PAYMENT</u>
<b><u>DIAGNOSTIC</u></b>		<b><u>ENDODONTICS</u></b>	
Consultation (excluding specialists)	_____	<b><u>Root Canal Therapy</u></b>	
Initial exam	_____	Anterior	_____
Periodic exam	_____	Bicuspid	_____
Limited exam	_____	Posterior	_____
<b><u>X-Rays</u></b>		Therapeutic pulpotomy (primary)	_____
Full mouth	_____	Therapeutic pulpotomy (permanent)	_____
4 Bite wing x-rays	_____	Apicoectomy (first root)	_____
Single film	_____	Retrograde filling (per root)	_____
Preventative education	_____		
<b><u>PREVENTATIVE</u></b>		<b><u>CROWNANDBRIDGE</u></b>	
Prophy cleaning (without fluoride)	_____	Stainless steel crown (primary)	_____
Prophy cleaning (with fluoride)	_____	Porcelain fused to metal	_____
Child prophy cleaning (with fluoride)	_____	Inceram crown	_____
Child prophy cleaning (without fluoride)	_____	Porcelain/gold crown (precious)	_____
Fluoride treatment (no other services)	_____	Endo post (preformed)	_____
Sealant (per tooth)	_____	Dowel post	_____
		Replace temporary crown	_____
		Recement (per unit)	_____
		Recement veneer	_____
<b><u>RESTORATIVEDENTISTRY</u></b>		<b><u>PROSTHODONTICS-DENTURES/PARTIALS</u></b>	
<b><u>Amalgam Fillings</u></b>		Complete Denture (upper or lower)	_____
<i>(primary or permanent teeth) (anterior or posterior teeth)</i>		Partial Denture (chrome cobalt alloy clasps)	_____
Single surface	_____	Immediate Denture	_____
Two surfaces	_____	Stayplate	_____
Three surfaces	_____	Adjust denture	_____
Four or more surfaces	_____	Office reline (tissue conditioning-per denture)	_____
<b><u>Composite Restorations</u></b>		Laboratory reline (per denture)	_____
<i>(primary or permanent teeth) (anterior or posterior teeth)</i>		Repair denture base (no teeth involved)	_____
Resin (1 surface)	_____	Repair missing/broken teeth (first tooth)	_____
Resin (2 surfaces)	_____	Additional teeth (per tooth)	_____
Resin (3 surfaces)	_____	Repair or replace clasp	_____
Resin (4 surfaces)	_____		
<b><u>COSMETICDENTISTRY</u></b>		<b><u>ORALSURGERY</u></b>	
Cosmetic bonding per tooth	_____	<b><u>Extractions</u></b>	
Laminates/Veneers	_____	Uncomplicated single tooth	_____
Bleaching (full mouth)	_____	Surgical removal of erupted teeth	_____
Teeth whitening	_____	Soft tissue impaction	_____
		Partial bony impaction	_____
<b><u>PERIODONTICS</u></b>		Complete bony impaction	_____
Perio recall	_____	Bone Graft (first site)	_____
Scaling root planing (per quadrant)	_____	Bone Graft (each additional site)	_____
Irrigation (per quadrant)	_____		
Crown lengthening (per tooth)	_____	Nitrous oxide anesthesia	_____
Nightguard	_____		