

Dental Benefits

January 1st - December 31st



For more information, please contact: Leon Medical Centers Health Plans Member Services at 1-866-393-5366 or 305-559-5366 [TTY: 711]. We're here from 8 a.m. to 8 p.m., seven days a week from October 1st through March 31st and Monday through Friday the rest of the year. You can also visit LMHealthplans.com.

2020 Dental Schedule of Benefits

This document describes your covered dental benefits and services. Note that some services are either limited or excluded. For questions about your dental benefits, or to find a network dentist in your area, visit LMChealthplans.com or call the Member Services number on your member ID card.

Deductible

There's no deductible under this dental plan.

Annual Maximum

There's a **\$2,300 maximum benefit** under this plan. This is the maximum dollar amount this dental plan will cover toward the cost of your dental care. You are responsible for paying all costs above the annual maximum amount.

Dental Benefits

The copayments listed in the table below only apply when you're treated by a general dentist or dental specialist in our network. If you get a service not listed in the schedule of benefits, or from a dentist or other provider not in our network, you'll have to pay the full cost.

You should discuss all treatment options with your network dentist and request a written treatment plan before getting work done.

Code	Description	Limitation	You Pay
Exams and X-rays (diagnostic)			
D0120	Periodic Oral Evaluation	1 per year	\$0
D0140	Limited Oral Evaluation - Problem Focused	1 per year	\$0
D0150	Comprehensive Oral Evaluation - New Or Established Patient	1 per year	\$0
D0171	Re-Evaluation – post-operative office visit		\$0
D0180	Comprehensive Periodontal Evaluation - New Or Established Patient	1 per 3 years	\$0
D0210	Intraoral - Complete Series of Radiographic Images	1 per year	\$0
D0220	Intraoral - periapical first radiographic image	1 per year	\$0
D0230	Intraoral - periapical each additional radiographic image	1 per year	\$0
D0240	Intraoral - occlusal radiographic image		\$0
D0270	Bitewing - Single Radiographic Image	1 per 6 months	\$0
D0272	Bitewings - Two Radiographic Images	1 per 6 months	\$0
D0274	Bitewings - Four Radiographic Images	1 per year	\$0
D0330	Panoramic Radiographic Image	1 per year	\$0
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible		\$0
Cleanings (preventive)			
D1110	Prophylaxis (Routine Cleaning) - Adult	1 per 6 months	\$0
D1204	Topical Application of Fluoride - Adult	1 per year	\$0
D1330	Oral hygiene instructions		\$0
Fillings (restorative)			
D2140	Amalgam - One Surface, Primary Or Permanent		\$0
D2150	Amalgam - Two Surfaces, Primary Or Permanent		\$0
D2160	Amalgam - Three Surfaces, Primary Or Permanent		\$0

Code	Description	Limitation	You Pay
Fillings (restorative)			
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent		\$0
D2330	Resin-Based Composite - One Surface, Anterior		\$0
D2331	Resin-Based Composite - Two Surfaces, Anterior		\$0
D2332	Resin-Based Composite - Three Surfaces, Anterior		\$0
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)		\$0
D2391	Resin-Based Composite - One Surface, Posterior		\$0
D2392	Resin-Based Composite - Two Surfaces, Posterior		\$0
D2393	Resin-Based Composite - Three Surfaces, Posterior		\$0
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior		\$0
D2740	Crown - Porcelain/Ceramic Substrate		\$0
D2750	Crown - Porcelain Fused To High Noble Metal		\$0
D2751	Crown - Porcelain Fused To Predominantly Base Metal		\$0
D2752	Crown - Porcelain Fused To Noble Metal		\$0
D2790	Crown - Full Cast High Noble Metal		\$0
D2920	Recement Or Re-Bond Crown		\$0
D2940	Protective Restoration		\$0
D2950	Core Buildup, Including Any Pins When Required		\$0
D2952	Post and core in addition to crown, indirectly fabricated		\$0

Code	Description	Limitation	You Pay
Fillings (restorative)			
D2954	Prefabricated Post And Core In Addition To Crown		\$0
D2955	Post Removal (Not In Conjunction With Endodontic Therapy)		\$0
Root Canals (endodontics)			
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)		\$0
D3221	Pulpal Debridement, Primary And Permanent Teeth		\$0
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)		\$0
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)		\$0
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth		\$0
D3999	Unspecified Endodontic Procedure, By Report		\$0
Gum and Bone Treatment (periodontics)			
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	1 per 6 months	\$0
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	1 per 6 months	\$0
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	1 per 6 months	\$0
D4342	Periodontal Scaling And Root Planing - One - Three Teeth, Per Quadrant	1 per 6 months	\$0
D4355	Full Mouth Debridement To Enable Comprehensive Evaluation And Diagnosis	1 per 6 months	\$0
D4910	Periodontal Maintenance	1 per 6 months	\$0

Code	Description	Limitation	You Pay
Dentures (removable prosthodontics)			
D5110	Complete Denture - Maxillary	1 set of any combination of maxillary and mandibular full/partial dentures every 5 years	\$0
D5120	Complete Denture - Mandibular	1 set of any combination of maxillary and mandibular full/partial dentures every 5 years	\$0
D5130	Immediate Denture - Maxillary	1 set of any combination of maxillary and mandibular full/partial dentures every 5 years	\$0
D5140	Immediate Denture - Mandibular	1 set of any combination of maxillary and mandibular full/partial dentures every 5 years	\$0
D5211	Maxillary Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	1 set of any combination of maxillary and mandibular full/partial dentures every 5 years	\$0
D5212	Mandibular Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	1 set of any combination of maxillary and mandibular full/partial dentures every 5 years	\$0

Code	Description	Limitation	You Pay
Dentures (removable prosthodontics)			
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)	1 set of any combination of maxillary and mandibular full/partial dentures every 5 years	\$0
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)	1 set of any combination of maxillary and mandibular full/partial dentures every 5 years	\$0
D5510	Repair Broken Complete Denture Base		\$0
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)		\$0
D5610	Repair Resin Denture Base		\$0
D5620	Repair Cast Framework		\$0
D5630	Repair Or Replace Broken Clasp - Per Tooth		\$0
D5640	Replace Broken Teeth - Per Tooth		\$0
D5650	Add Tooth To Existing Partial Denture		\$0
D5660	Add Clasp To Existing Partial Denture - Per Tooth		\$0
D5710	Rebase Complete Maxillary Denture		\$0
D5711	Rebase Complete Mandibular Denture		\$0
D5720	Rebase Maxillary Partial Denture		\$0
D5721	Rebase Mandibular Partial Denture		\$0
D5730	Reline Complete Maxillary Denture (Chairside)		\$0
D5731	Reline Complete Mandibular Denture (Chairside)		\$0
D5740	Reline Maxillary Partial Denture (Chairside)		\$0
D5741	Reline Mandibular Partial Denture (Chairside)		\$0
D5750	Reline Complete Maxillary Denture (Laboratory)		\$0

Code	Description	Limitation	You Pay
Dentures (removable prosthodontics)			
D5751	Reline Complete Mandibular Denture (Laboratory)		\$0
D5760	Reline Maxillary Partial Denture (Laboratory)		\$0
D5761	Reline Mandibular Partial Denture (Laboratory)		\$0
D5875	Modification Of Removable Prosthesis Following Implant Surgery		\$0
Dental Implants <i>To support the lower full denture on fully edentulous lower arch only. Does not include membranes and/or bone replacement or graft.</i>			
D6010	Surgical placement of implant body: endosteal implant	2 per 5 years	\$0
D6020	Abutment placement or substitution: endosteal implant		\$0
D6052	Semi-precision attachment abutment		\$0
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular		\$0
Crowns (fixed prosthodontics)			
D6750	Retainer Crown - Porcelain Fused To High Noble Metal		\$0
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal		\$0
D6930	Recement or Re-Bond Fixed Partial Denture		\$0
D6999	Unspecified Fixed Prosthodontic Procedure, by report		\$0

Code	Description	Limitation	You Pay
Extractions and Removals (oral and maxillofacial surgery)			
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation and/or Forceps Removal)		\$0
D7210	Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and Including Elevation of Mucoperiosteal Flap if Indicated		\$0
D7220	Removal Of Impacted Tooth - Soft Tissue		\$0
D7230	Removal Of Impacted Tooth - Partially Bony		\$0
D7240	Removal Of Impacted Tooth - Completely Bony		\$0
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications		\$0
D7250	Surgical Removal Of Residual Tooth Roots (Cutting Procedure)		\$0
D7260	Oroantral Fistula Closure		\$0
D7261	Primary Closure Of A Sinus Perforation		\$0
D7286	Incisional Biopsy Of Oral Tissue - Soft		\$0
D7287	Exfoliative Cytological Sample Collection		\$0
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant		\$0
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant		\$0
D7410	Excision Of Benign Lesion Up To 1.25 Cm		\$0
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm		\$0
D7471	Removal Of Exostosis - Per Site		\$0
D7472	Removal Of Torus Palatinus		\$0
D7473	Removal Of Torus Mandibularis		\$0
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		\$0
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		\$0

Code	Description	Limitation	You Pay
Extractions and Removals (oral and maxillofacial surgery)			
D7970	Excision Of Hyperplastic Tissue - Per Arch		\$0
Non-routine Services			
D9210	Local Anesthesia Not In Conjunction With Operative Or Surgical Procedures		\$0
D9215	Local Anesthesia In Conjunction With Operative Or Surgical Procedures		\$0
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician		\$0
D9940	Occlusal Guard, By Report		\$0

Non-covered Services

The plan does not cover the following:

- Dental services not listed in this Schedule of Benefits
- Dental services received from an out-of-network dentist
- Services or items listed in the Exclusions section or dental services that exceed frequency limitations

You're responsible for all charges related to any excluded services. You must also pay the costs of any services received greater than the limits specified.

EXCLUSIONS

- Oral surgery requiring the setting of fractures or dislocations.
- Any treatment, which cannot be, performed due to the general health and physical limits of the eligible member, as indicated by said member's personal physician or dentist.
- Any dental procedure considered experimental.
- Any treatment paid for by Worker's Compensation or employer's liability laws, by a federal; or state government agency or other insurance coverage carried by the member. Any treatment provided without cost by any municipality, county or other political subdivision.
- The administration of general anesthesia.
- Any dental care provided by a non-participating general dentist or specialist.

- Services resulting from any act of war, declared or not, or resulting from military services.
- The dentist shall have the right to refuse treatment to a member who fails to follow a prescribed course of treatment.
- Any dental treatment started and or completed prior to the member's effective date for eligibility of dental benefits including but not limited to teeth prepared for crowns, root canals in progress and dental implants.
- Any services associated with dental implants not originally placed by a Leon Medical Center participating provider.
- All related fees for admission, use, or stays in a hospital, outpatient surgery center or other similar care facility.
- Any procedure that in the professional opinion of the participating dentist or specialist: 1) has poor probability for success based on the condition of the tooth or teeth and or implants or surrounding structures, 2) is inconsistent with generally accepted standards for dentistry.
- Restorations placed solely for cosmetic reasons.
- D4381 – Localized Delivery of Antimicrobial Agents.
- Extractions of teeth, when teeth are asymptomatic show no signs of infection, including but not limited to the removal of third molars.
- Treatment or extraction of non-infected primary teeth when normal loss is imminent.
- Accidental injury defined as damage to the hard and soft tissue of the oral cavity resulting from forces external to the mouth.
- Exams or consultation for non-covered benefits and out-of-network procedures.
- Orthodontic procedures and/or services in general.
- Fabrication of D5225 and D5226 (flex-base partials) or services related to those appliances.
- The benefits schedule is valid at Leon Medical Centers' dental facilities and contracted specialist dental offices only.

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