Group Dental Insurance

RFP No.: DMS 16/17-016

Attachment 6

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL INSURANCE POLICY

The Policyholder	**STATE OF FLORIDA**		
		Policy Number	**10-350557**
State of Delivery	**Florida**	**Plan Effective Date**	**January 1, 2008**
		Plan Change Effective Date	**January 1, 2017**
Premium Due Date 1st of each month.		**Renewal Date**	**January 1, 2010**

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

When a purchaser of insurance terminated or replaces an existing group with another such policy, the prior insurer shall remain liable only to the extent of its accrued liabilities and extensions of benefits as required by s. 627.667.

The insurer must give the policyholder at least 45 days advance notice of cancellation, expiration, non-renewal or change in rates.

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 877-721-2224.

AMERITAS LIFE INSURANCE CORP.

Corporate Secretary

President

FLORIDA IMPORTANT INFORMATION TO INSUREDS

We are here to serve you . . .

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

Name:	Quality Control
Address:	P.O. Box 82657
	Lincoln, NE 68501-2657
Phone:	877-897-4328
Fax:	402-309-2579

The complaint will be carefully reviewed. If the initial claim was denied based on clinical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within 15 business days following the receipt of the appeal.

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the Florida Office of Insurance Regulation with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact them, write or call:

Division of Consumer Services
Department of Financial Regulation
200 East Gaines Street
Tallahassee, FL 32399
(877) 693-5236 or (850) 413-3089

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	All Eligible Employees

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,000

In no event will expenses incurred for Type 1 Procedures count toward the Maximum Benefit.

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Dental Care Insurance	$10.20 per Insured Person
	$10.56 Spouse Only
	$16.80 Child(ren) Only
	$27.36 Spouse & Child(ren)

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums (premium for the period which claims were not paid) to the Policyholder only for the 0 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 45 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, We the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of any one or more of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of those Insureds initially enrolled under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date: and/or

3. We are required by either the federal government or by any state or local government or by any agency thereof to pay a new or increased tax, assessment, or monetary charge of any kind (other than a new or any increase to the amount of tax we pay based upon our net operating income). Such taxes, assessments or fees would include those that are charged or assessed in connection with the operation of a health care exchange authorized by federal or state law.

Should any of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 45 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE Renewal Date refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. an Insured's spouse.

b. each child through the end of the calendar year in which they turn age 26, for whom the Insured or the Insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code.

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

   The child must be dependent upon the certificateholder for support and either living in the household of the certificateholder or is a full or part-time student.

c. each child age 26 or older who:

   i. is Totally Disabled due to mental or physical reasons; and

   ii. becomes Totally Disabled while insured as a dependent under b. above.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider." The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any full time active employee working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If both spouses are Members and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for all covered Dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, including the necessary care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured may give us written notice within 61 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 61-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any full time active employee working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1. A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. 1 on 9219. (There is NO "open enrollment" under this policy.)

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become members after the Plan Effective Date of the policy, qualification will occur the first of the month following the collection of one full month's premium.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he

or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

i. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

ii. the person is considered a Member or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. For those Dependents whose coverage terminates because they no longer meet the definition of a Dependent as a result of a limiting age (See "Definitions"), insurance will continue in force throughout the remainder of that year but will automatically terminate December 31 of the year following the attainment of that limiting age.

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as covered under your plan.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. The policy provides an extension of benefits if all the following conditions are met:

1. Only dental procedures, as defined within the Table of Dental Procedures, are eligible for this extension, **except** for the dental procedures performed for routine examinations, cleanings, radiographic images and sealants.

2. The dental procedures must have been performed within 90 days after an Insured's insurance terminates due to discontinuance of the policy.

3. The course of dental treatment or dental procedures must have been recommended to the Insured by a provider in writing and commenced while insurance was in effect for the Insured.

4. Any dental procedures performed in the 90-day extension period are subject to the same policy provisions that would have applied had the Insured's insurance still been in effect.

5. To be eligible for this extension, the Insured is not required to be totally disabled.

When all the foregoing conditions have been met, dental procedures performed after the insurance on an Insured terminates will be considered as if the Insured's insurance was still in effect.

This extension will terminate on the earlier of:

1. the end of the 90-day extension period; and

2. the date the Insured is covered under another group health plan providing similar dental coverage. However, the extension will not terminate if the succeeding plan excludes the dental procedures eligible for extension with a waiting period.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

2. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is paid benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not. However, terrorism, or any act of terrorism, will not be excluded.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Ø Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.

- Ø Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

- Ø Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review. Examples of procedures which may be subject to Alternate Benefits are crowns, inlays, onlays, fixed partial dentures, composite restorations, and overdentures. Examples of procedures which may be subject to plan payments based on consultant review are services related to oral maxillofacial surgery, fixed partial dentures, periodontics, and endodontics.

- Ø Reference to "traumatic injury" under this plan is defined as any injury caused by an object or a force other than bruxism (grinding of teeth).

- Ø Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.

- Ø B/R means By Report.

- Ø We may request radiographs, periodontal charting, surgical notes, narratives, photos and/or a patient's records on any procedure for our dental consultants to review. Commonly reviewed procedures include: Periodontic procedures, Oral Maxillofacial Surgical procedures, Implants, Crowns, Inlays, Onlays, Core Build-Ups, Fixed Partial Dentures, Post and Cores, Veneers, Endodontic Retreatment, and Apexification/Recalcification procedures.

- Ø We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.

- Ø A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$14.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$11.00
D0150	Comprehensive oral evaluation - new or established patient.	$22.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$22.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC		
D0210	Intraoral - complete series of radiographic images.	$45.00
D0330	Panoramic radiographic image.	$36.00

COMPLETE SERIES/PANORAMIC: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first radiographic image.	$8.00
D0230	Intraoral - periapical each additional radiographic image.	$6.00
D0240	Intraoral - occlusal radiographic image.	$11.00
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.	$15.00
D0251	Extra-oral posterior dental radiographic image.	$15.00

PERIAPICAL: D0220, D0230

- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS		
D0270	Bitewing - single radiographic image.	$7.00
D0272	Bitewings - two radiographic images.	$13.00
D0273	Bitewings - three radiographic images.	$15.00
D0274	Bitewings - four radiographic images.	$20.00
D0277	Vertical bitewings - 7 to 8 radiographic images.	$30.00

BITEWINGS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$30.00

TYPE 1 PROCEDURES

		Maximum Covered Expense
D1120	Prophylaxis - child.	$21.00
D1206	Topical application of fluoride varnish.	$11.00
D1208	Topical application of fluoride-excluding varnish.	$11.00
D9932	Cleaning and inspection of removable complete denture, maxillary.	$30.00
D9933	Cleaning and inspection of removable complete denture, mandibular.	$30.00
D9934	Cleaning and inspection of removable partial denture, maxillary.	$30.00
D9935	Cleaning and inspection of removable partial denture, mandibular.	$30.00

FLUORIDE: D1206, D1208

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

PROSTHODONTIC PROPHYLAXIS: D9932, D9933, D9934, D9935

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- Not allowed when done on the same date as periodontal services.

SEALANT

D1351	Sealant - per tooth.	$17.00
D1352	Preventive resin restoration in a moderate to high caries risk patient-permanent.	$17.00
D1353	Sealant repair - per tooth.	$17.00

SEALANT: D1351, D1352, D1353

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$106.00
D1515	Space maintainer - fixed - bilateral.	$174.00
D1520	Space maintainer - removable - unilateral.	$166.00
D1525	Space maintainer - removable - bilateral.	$202.00
D1550	Re-cement or re-bond space maintainer.	$22.00
D1555	Removal of fixed space maintainer.	$30.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$160.00
D8220	Fixed appliance therapy.	$160.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

OCCLUSAL GUARD

D9940	Occlusal guard, by report.	$101.00

OCCLUSAL GUARD: D9940

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits will not be available if performed for athletic purposes.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$15.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$15.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$18.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$35.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$35.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$25.00
D2150	Amalgam - two surfaces, primary or permanent.	$32.00
D2160	Amalgam - three surfaces, primary or permanent.	$38.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$46.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$30.00
D2331	Resin-based composite - two surfaces, anterior.	$38.00
D2332	Resin-based composite - three surfaces, anterior.	$48.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$53.00
D2391	Resin-based composite - one surface, posterior.	$33.00
D2392	Resin-based composite - two surfaces, posterior.	$42.00
D2393	Resin-based composite - three surfaces, posterior.	$53.00
D2394	Resin-based composite - four or more surfaces, posterior.	$58.00
D2410	Gold foil - one surface.	$25.00
D2420	Gold foil - two surfaces.	$32.00
D2430	Gold foil - three surfaces.	$38.00
D2990	Resin infiltration of incipient smooth surface lesions.	$30.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)		
D2390	Resin-based composite crown, anterior.	$65.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth.	$60.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2930	Prefabricated stainless steel crown - primary tooth.	$54.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$58.00
D2932	Prefabricated resin crown.	$65.00
D2933	Prefabricated stainless steel crown with resin window.	$65.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$65.00

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.	$20.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core.	$10.00
D2920	Re-cement or re-bond crown.	$20.00
D2921	Reattachment of tooth fragment, incisal edge or cusp.	$48.00
D6092	Re-cement or re-bond implant/abutment supported crown.	$20.00
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture.	$20.00
D6930	Re-cement or re-bond fixed partial denture.	$27.00

SEDATIVE FILLING

D2940	Protective restoration.	$18.00
D2941	Interim therapeutic restoration - primary dentition.	$14.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$34.00
D3221	Pulpal debridement, primary and permanent teeth.	$34.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$51.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$45.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$39.00
D3333	Internal root repair of perforation defects.	$55.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).	$55.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).	$38.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$110.00
D3357	Pulpal regeneration - completion of treatment.	$110.00
D3430	Retrograde filling - per root.	$43.00
D3450	Root amputation - per root.	$103.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$87.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$154.00
D3320	Endodontic therapy, bicuspid tooth.	$182.00
D3330	Endodontic therapy, molar.	$238.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$91.00
D3346	Retreatment of previous root canal therapy - anterior.	$192.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$221.00
D3348	Retreatment of previous root canal therapy - molar.	$275.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.

		Maximum Covered Expense
	• Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.	
SURGICAL ENDODONTICS		
D3355	Pulpal regeneration - initial visit.	$55.00
D3356	Pulpal regeneration - interim medication replacement.	$38.00
D3410	Apicoectomy - anterior.	$159.00
D3421	Apicoectomy - bicuspid (first root).	$183.00
D3425	Apicoectomy - molar (first root).	$198.00
D3426	Apicoectomy (each additional root).	$71.00
D3427	Periradicular surgery without apicoectomy.	$143.00
SURGICAL PERIODONTICS		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$100.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$50.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$138.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$69.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$253.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$127.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant.	$83.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant.	$62.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$41.00
D4270	Pedicle soft tissue graft procedure.	$186.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.	$230.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).	$111.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.	$197.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$230.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.	$198.00
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.	$79.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.	$230.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.	$89.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TYPE 2 PROCEDURES

		Maximum Covered Expense
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$52.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$26.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$38.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT		
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$31.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE		
D4910	Periodontal maintenance.	$32.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR		
D5510	Repair broken complete denture base.	$32.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$26.00
D5610	Repair resin denture base.	$31.00
D5620	Repair cast framework.	$37.00
D5630	Repair or replace broken clasp-per tooth.	$39.00
D5640	Replace broken teeth - per tooth.	$28.00
DENTURE RELINES		
D5730	Reline complete maxillary denture (chairside).	$58.00
D5731	Reline complete mandibular denture (chairside).	$58.00
D5740	Reline maxillary partial denture (chairside).	$52.00
D5741	Reline mandibular partial denture (chairside).	$53.00
D5750	Reline complete maxillary denture (laboratory).	$87.00
D5751	Reline complete mandibular denture (laboratory).	$85.00
D5760	Reline maxillary partial denture (laboratory).	$87.00
D5761	Reline mandibular partial denture (laboratory).	$87.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS		
D7111	Extraction, coronal remnants - deciduous tooth.	$28.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$28.00
SURGICAL EXTRACTIONS		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	$54.00
D7220	Removal of impacted tooth - soft tissue.	$67.00
D7230	Removal of impacted tooth - partially bony.	$89.00
D7240	Removal of impacted tooth - completely bony.	$104.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$119.00
D7250	Removal of residual tooth roots (cutting procedure).	$56.00
D7251	Coronectomy-intentional partial tooth removal.	$104.00
OTHER ORAL SURGERY		
D7260	Oroantral fistula closure.	$132.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7261	Primary closure of a sinus perforation.	$132.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$80.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$80.00
D7280	Exposure of an unerupted tooth.	$123.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$89.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$37.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$46.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$23.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$59.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$30.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$85.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$211.00
D7410	Excision of benign lesion up to 1.25 cm.	$84.00
D7411	Excision of benign lesion greater than 1.25 cm.	$108.00
D7412	Excision of benign lesion, complicated.	$119.00
D7413	Excision of malignant lesion up to 1.25 cm.	$114.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$83.00
D7415	Excision of malignant lesion, complicated.	$92.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$114.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$83.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$84.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$108.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$84.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$108.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$25.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$75.00
D7472	Removal of torus palatinus.	$75.00
D7473	Removal of torus mandibularis.	$75.00
D7485	Reduction of osseous tuberosity.	$122.00
D7490	Radical resection of maxilla or mandible.	$114.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$38.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$43.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$35.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$95.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$95.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$125.00
D7910	Suture of recent small wounds up to 5 cm.	$17.00
D7911	Complicated suture - up to 5 cm.	$19.00
D7912	Complicated suture - greater than 5 cm.	$27.00
D7960	Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.	$90.00
D7963	Frenuloplasty.	$113.00
D7970	Excision of hyperplastic tissue - per arch.	$70.00
D7972	Surgical reduction of fibrous tuberosity.	$111.00
D7980	Sialolithotomy.	$104.00
D7983	Closure of salivary fistula.	$33.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Incisional biopsy of oral tissue - hard (bone, tooth).	$113.00
D7286	Incisional biopsy of oral tissue - soft.	$61.00
D7287	Exfoliative cytological sample collection.	$30.00
D7288	Brush biopsy - transepithelial sample collection.	$30.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
PALLIATIVE		
D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$21.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV		
D9219	Evaluation for deep sedation or general anesthesia.	$16.00
D9223	Deep sedation/general anesthesia - each 15 minute increment.	$32.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment.	$27.00

GENERAL ANESTHESIA: D9223, D9243

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report are required. A maximum of four (D9223 or D9243) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES		
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$21.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$15.00
D9440	Office visit - after regularly scheduled hours.	$26.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$16.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT		
D9951	Occlusal adjustment - limited.	$20.00
D9952	Occlusal adjustment - complete.	$100.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS		
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	$18.00
D2951	Pin retention - per tooth, in addition to restoration.	$10.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$30.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$103.00
D2520	Inlay - metallic - two surfaces.	$123.00
D2530	Inlay - metallic - three or more surfaces.	$132.00
D2610	Inlay - porcelain/ceramic - one surface.	$114.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$123.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$135.00
D2650	Inlay - resin-based composite - one surface.	$118.00
D2651	Inlay - resin-based composite - two surfaces.	$116.00
D2652	Inlay - resin-based composite - three or more surfaces.	$120.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$133.00
D2543	Onlay - metallic - three surfaces.	$149.00
D2544	Onlay - metallic - four or more surfaces.	$155.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$133.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$149.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$154.00
D2662	Onlay - resin-based composite - two surfaces.	$125.00
D2663	Onlay - resin-based composite - three surfaces.	$129.00
D2664	Onlay - resin-based composite - four or more surfaces.	$137.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$58.00
D2712	Crown - 3/4 resin-based composite (indirect).	$145.00
D2720	Crown - resin with high noble metal.	$149.00
D2721	Crown - resin with predominantly base metal.	$114.00
D2722	Crown - resin with noble metal.	$139.00
D2740	Crown - porcelain/ceramic substrate.	$161.00
D2750	Crown - porcelain fused to high noble metal.	$156.00
D2751	Crown - porcelain fused to predominantly base metal.	$134.00
D2752	Crown - porcelain fused to noble metal.	$144.00
D2780	Crown - 3/4 cast high noble metal.	$149.00
D2781	Crown - 3/4 cast predominantly base metal.	$129.00
D2782	Crown - 3/4 cast noble metal.	$135.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$161.00
D2790	Crown - full cast high noble metal.	$149.00
D2791	Crown - full cast predominantly base metal.	$129.00
D2792	Crown - full cast noble metal.	$135.00
D2794	Crown - titanium.	$149.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins when required.	$32.00

CORE BUILDUP: D2950

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$51.00
D2954	Prefabricated post and core in addition to crown.	$43.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair necessitated by restorative material failure.	$26.00
D2981	Inlay repair necessitated by restorative material failure.	$21.00
D2982	Onlay repair necessitated by restorative material failure.	$21.00
D2983	Veneer repair necessitated by restorative material failure.	$21.00
D6980	Fixed partial denture repair necessitated by restorative material failure.	$29.00
D9120	Fixed partial denture sectioning.	$29.00

CROWN LENGTHENING

D4249	Clinical crown lengthening - hard tissue.	$92.00

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$166.00
D5120	Complete denture - mandibular.	$161.00
D5130	Immediate denture - maxillary.	$180.00
D5140	Immediate denture - mandibular.	$174.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$120.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$139.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$120.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$139.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$120.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$139.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$103.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$120.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$139.00
D5810	Interim complete denture (maxillary).	$73.00
D5811	Interim complete denture (mandibular).	$77.00
D5820	Interim partial denture (maxillary).	$65.00
D5821	Interim partial denture (mandibular).	$68.00
D5863	Overdenture - complete maxillary.	$166.00
D5864	Overdenture - partial maxillary.	$193.00
D5865	Overdenture - complete mandibular.	$166.00
D5866	Overdenture - partial mandibular.	$193.00
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary.	$166.00
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular.	$166.00
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary.	$193.00
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular.	$193.00
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary.	$166.00
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular.	$166.00
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary.	$193.00
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular.	$193.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6110, D6111, D6114, D6115

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$9.00
D5411	Adjust complete denture - mandibular.	$9.00
D5421	Adjust partial denture - maxillary.	$10.00
D5422	Adjust partial denture - mandibular.	$9.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	$21.00
D5660	Add clasp to existing partial denture-per tooth.	$25.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$61.00
D5711	Rebase complete mandibular denture.	$64.00
D5720	Rebase maxillary partial denture.	$58.00
D5721	Rebase mandibular partial denture.	$61.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	$17.00
D5851	Tissue conditioning, mandibular.	$18.00

PROSTHODONTICS - FIXED

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6058	Abutment supported porcelain/ceramic crown.	$139.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$151.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$151.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$139.00
D6062	Abutment supported cast metal crown (high noble metal).	$151.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$151.00
D6064	Abutment supported cast metal crown (noble metal).	$164.00
D6065	Implant supported porcelain/ceramic crown.	$139.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$151.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$151.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$139.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$151.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$151.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$139.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$151.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$151.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$164.00
D6075	Implant supported retainer for ceramic FPD.	$139.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$151.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$151.00
D6094	Abutment supported crown - (titanium).	$151.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$151.00
D6205	Pontic - indirect resin based composite.	$125.00
D6210	Pontic - cast high noble metal.	$151.00
D6211	Pontic - cast predominantly base metal.	$151.00
D6212	Pontic - cast noble metal.	$164.00
D6214	Pontic - titanium.	$151.00
D6240	Pontic - porcelain fused to high noble metal.	$151.00
D6241	Pontic - porcelain fused to predominantly base metal.	$151.00
D6242	Pontic - porcelain fused to noble metal.	$139.00
D6245	Pontic - porcelain/ceramic.	$139.00
D6250	Pontic - resin with high noble metal.	$151.00
D6251	Pontic - resin with predominantly base metal.	$139.00
D6252	Pontic - resin with noble metal.	$164.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$50.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$50.00
D6549	Resin retainer - for resin bonded fixed prosthesis.	$50.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces.	$123.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces.	$136.00
D6602	Retainer inlay - cast high noble metal, two surfaces.	$111.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces.	$122.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces.	$96.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces.	$105.00
D6606	Retainer inlay - cast noble metal, two surfaces.	$101.00
D6607	Retainer inlay - cast noble metal, three or more surfaces.	$111.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces.	$133.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces.	$147.00
D6610	Retainer onlay - cast high noble metal, two surfaces.	$122.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces.	$134.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces.	$105.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces.	$116.00
D6614	Retainer onlay - cast noble metal, two surfaces.	$111.00
D6615	Retainer onlay - cast noble metal, three or more surfaces.	$122.00
D6624	Retainer inlay - titanium.	$122.00
D6634	Retainer onlay - titanium.	$134.00
D6710	Retainer crown - indirect resin based composite.	$125.00
D6720	Retainer crown - resin with high noble metal.	$151.00
D6721	Retainer crown - resin with predominantly base metal.	$78.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6722	Retainer crown - resin with noble metal.	$126.00
D6740	Retainer crown - porcelain/ceramic.	$139.00
D6750	Retainer crown - porcelain fused to high noble metal.	$164.00
D6751	Retainer crown - porcelain fused to predominantly base metal.	$151.00
D6752	Retainer crown - porcelain fused to noble metal.	$139.00
D6780	Retainer crown - 3/4 cast high noble metal.	$164.00
D6781	Retainer crown - 3/4 cast predominantly base metal.	$151.00
D6782	Retainer crown - 3/4 cast noble metal.	$139.00
D6783	Retainer crown - 3/4 porcelain/ceramic.	$139.00
D6790	Retainer crown - full cast high noble metal.	$151.00
D6791	Retainer crown - full cast predominantly base metal.	$151.00
D6792	Retainer crown - full cast noble metal.	$139.00
D6794	Retainer crown - titanium.	$151.00
D6940	Stress breaker.	$42.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

        If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

        However, if the specific terms of a court decree establish a parent's responsibility for the child's Dental expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to $500.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than the applicable statute of limitations after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

GENERAL PROVISIONS (CONTINUED)

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to void the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	20%
Number of Members-	1,493

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

Dental Utilization Review Program. Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: STATE OF FLORIDA

whose main office address is: 4050 ESPLANADE WAY STE 215.6Y
TALLAHASSEE, FL 32399-7016

for Group Policy No. 10-350557

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

STATE OF FLORIDA

(Full or Corporate Name of Applicant)

Dated at_____By_____
(Signature and Title)

On_____, 20__ Witness_____
(To be signed by Resident Agent where required by law)

This copy is to Remain Attached to the Policy

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL INSURANCE POLICY

The Policyholder	**STATE OF FLORIDA**		
		Policy Number	**10-350557**
State of Delivery	**Florida**	**Plan Effective Date**	**January 1, 2008**
		Plan Change Effective Date	**January 1, 2017**
Premium Due Date 1st of each month.		**Renewal Date**	**January 1, 2010**

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

When a purchaser of insurance terminated or replaces an existing group with another such policy, the prior insurer shall remain liable only to the extent of its accrued liabilities and extensions of benefits as required by s. 627.667.

The insurer must give the policyholder at least 45 days advance notice of cancellation, expiration, non-renewal or change in rates.

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 877-721-2224.

AMERITAS LIFE INSURANCE CORP.

Corporate Secretary

President

FLORIDA IMPORTANT INFORMATION TO INSUREDS

We are here to serve you . . .

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

Name:	Quality Control
Address:	P.O. Box 82657
	Lincoln, NE 68501-2657
Phone:	877-897-4328
Fax:	402-309-2579

The complaint will be carefully reviewed. If the initial claim was denied based on clinical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within 15 business days following the receipt of the appeal.

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the Florida Office of Insurance Regulation with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact them, write or call:

Division of Consumer Services
Department of Financial Regulation
200 East Gaines Street
Tallahassee, FL 32399
(877) 693-5236 or (850) 413-3089

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	All Eligible Employees

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,000

In no event will expenses incurred for Type 1 Procedures count toward the Maximum Benefit.

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Dental Care Insurance	$10.20 per Insured Person
	$10.56 Spouse Only
	$16.80 Child(ren) Only
	$27.36 Spouse & Child(ren)

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums (premium for the period which claims were not paid) to the Policyholder only for the 0 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 45 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, We the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of any one or more of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of those Insureds initially enrolled under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date: and/or

3. We are required by either the federal government or by any state or local government or by any agency thereof to pay a new or increased tax, assessment, or monetary charge of any kind (other than a new or any increase to the amount of tax we pay based upon our net operating income). Such taxes, assessments or fees would include those that are charged or assessed in connection with the operation of a health care exchange authorized by federal or state law.

Should any of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 45 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE Renewal Date refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. an Insured's spouse.

b. each child through the end of the calendar year in which they turn age 26, for whom the Insured or the Insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code.

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

   The child must be dependent upon the certificateholder for support and either living in the household of the certificateholder or is a full or part-time student.

c. each child age 26 or older who:

   i. is Totally Disabled due to mental or physical reasons; and

   ii. becomes Totally Disabled while insured as a dependent under b. above.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider." The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any full time active employee working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If both spouses are Members and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for all covered Dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, including the necessary care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured may give us written notice within 61 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 61-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any full time active employee working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1. A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. 1 on 9219. (There is NO "open enrollment" under this policy.)

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become members after the Plan Effective Date of the policy, qualification will occur the first of the month following the collection of one full month's premium.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he

or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

i. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

ii. the person is considered a Member or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. For those Dependents whose coverage terminates because they no longer meet the definition of a Dependent as a result of a limiting age (See "Definitions"), insurance will continue in force throughout the remainder of that year but will automatically terminate December 31 of the year following the attainment of that limiting age.

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as covered under your plan.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. The policy provides an extension of benefits if all the following conditions are met:

1. Only dental procedures, as defined within the Table of Dental Procedures, are eligible for this extension, **except** for the dental procedures performed for routine examinations, cleanings, radiographic images and sealants.

2. The dental procedures must have been performed within 90 days after an Insured's insurance terminates due to discontinuance of the policy.

3. The course of dental treatment or dental procedures must have been recommended to the Insured by a provider in writing and commenced while insurance was in effect for the Insured.

4. Any dental procedures performed in the 90-day extension period are subject to the same policy provisions that would have applied had the Insured's insurance still been in effect.

5. To be eligible for this extension, the Insured is not required to be totally disabled.

When all the foregoing conditions have been met, dental procedures performed after the insurance on an Insured terminates will be considered as if the Insured's insurance was still in effect.

This extension will terminate on the earlier of:

1. the end of the 90-day extension period; and

2. the date the Insured is covered under another group health plan providing similar dental coverage. However, the extension will not terminate if the succeeding plan excludes the dental procedures eligible for extension with a waiting period.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

2. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is paid benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not. However, terrorism, or any act of terrorism, will not be excluded.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Ø Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.

- Ø Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

- Ø Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review. Examples of procedures which may be subject to Alternate Benefits are crowns, inlays, onlays, fixed partial dentures, composite restorations, and overdentures. Examples of procedures which may be subject to plan payments based on consultant review are services related to oral maxillofacial surgery, fixed partial dentures, periodontics, and endodontics.

- Ø Reference to "traumatic injury" under this plan is defined as any injury caused by an object or a force other than bruxism (grinding of teeth).

- Ø Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.

- Ø B/R means By Report.

- Ø We may request radiographs, periodontal charting, surgical notes, narratives, photos and/or a patient's records on any procedure for our dental consultants to review. Commonly reviewed procedures include: Periodontic procedures, Oral Maxillofacial Surgical procedures, Implants, Crowns, Inlays, Onlays, Core Build-Ups, Fixed Partial Dentures, Post and Cores, Veneers, Endodontic Retreatment, and Apexification/Recalcification procedures.

- Ø We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.

- Ø A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$14.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$11.00
D0150	Comprehensive oral evaluation - new or established patient.	$22.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$22.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC		
D0210	Intraoral - complete series of radiographic images.	$45.00
D0330	Panoramic radiographic image.	$36.00

COMPLETE SERIES/PANORAMIC: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first radiographic image.	$8.00
D0230	Intraoral - periapical each additional radiographic image.	$6.00
D0240	Intraoral - occlusal radiographic image.	$11.00
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.	$15.00
D0251	Extra-oral posterior dental radiographic image.	$15.00

PERIAPICAL: D0220, D0230

- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS		
D0270	Bitewing - single radiographic image.	$7.00
D0272	Bitewings - two radiographic images.	$13.00
D0273	Bitewings - three radiographic images.	$15.00
D0274	Bitewings - four radiographic images.	$20.00
D0277	Vertical bitewings - 7 to 8 radiographic images.	$30.00

BITEWINGS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$30.00

TYPE 1 PROCEDURES

		Maximum Covered Expense
D1120	Prophylaxis - child.	$21.00
D1206	Topical application of fluoride varnish.	$11.00
D1208	Topical application of fluoride-excluding varnish.	$11.00
D9932	Cleaning and inspection of removable complete denture, maxillary.	$30.00
D9933	Cleaning and inspection of removable complete denture, mandibular.	$30.00
D9934	Cleaning and inspection of removable partial denture, maxillary.	$30.00
D9935	Cleaning and inspection of removable partial denture, mandibular.	$30.00

FLUORIDE: D1206, D1208

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

PROSTHODONTIC PROPHYLAXIS: D9932, D9933, D9934, D9935

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- Not allowed when done on the same date as periodontal services.

SEALANT

D1351	Sealant - per tooth.	$17.00
D1352	Preventive resin restoration in a moderate to high caries risk patient-permanent.	$17.00
D1353	Sealant repair - per tooth.	$17.00

SEALANT: D1351, D1352, D1353

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$106.00
D1515	Space maintainer - fixed - bilateral.	$174.00
D1520	Space maintainer - removable - unilateral.	$166.00
D1525	Space maintainer - removable - bilateral.	$202.00
D1550	Re-cement or re-bond space maintainer.	$22.00
D1555	Removal of fixed space maintainer.	$30.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$160.00
D8220	Fixed appliance therapy.	$160.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

OCCLUSAL GUARD

D9940	Occlusal guard, by report.	$101.00

OCCLUSAL GUARD: D9940

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits will not be available if performed for athletic purposes.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$15.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$15.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$18.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$35.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$35.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$25.00
D2150	Amalgam - two surfaces, primary or permanent.	$32.00
D2160	Amalgam - three surfaces, primary or permanent.	$38.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$46.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$30.00
D2331	Resin-based composite - two surfaces, anterior.	$38.00
D2332	Resin-based composite - three surfaces, anterior.	$48.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$53.00
D2391	Resin-based composite - one surface, posterior.	$33.00
D2392	Resin-based composite - two surfaces, posterior.	$42.00
D2393	Resin-based composite - three surfaces, posterior.	$53.00
D2394	Resin-based composite - four or more surfaces, posterior.	$58.00
D2410	Gold foil - one surface.	$25.00
D2420	Gold foil - two surfaces.	$32.00
D2430	Gold foil - three surfaces.	$38.00
D2990	Resin infiltration of incipient smooth surface lesions.	$30.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)		
D2390	Resin-based composite crown, anterior.	$65.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth.	$60.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2930	Prefabricated stainless steel crown - primary tooth.	$54.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$58.00
D2932	Prefabricated resin crown.	$65.00
D2933	Prefabricated stainless steel crown with resin window.	$65.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$65.00

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.	$20.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core.	$10.00
D2920	Re-cement or re-bond crown.	$20.00
D2921	Reattachment of tooth fragment, incisal edge or cusp.	$48.00
D6092	Re-cement or re-bond implant/abutment supported crown.	$20.00
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture.	$20.00
D6930	Re-cement or re-bond fixed partial denture.	$27.00

SEDATIVE FILLING

D2940	Protective restoration.	$18.00
D2941	Interim therapeutic restoration - primary dentition.	$14.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$34.00
D3221	Pulpal debridement, primary and permanent teeth.	$34.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$51.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$45.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$39.00
D3333	Internal root repair of perforation defects.	$55.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).	$55.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).	$38.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$110.00
D3357	Pulpal regeneration - completion of treatment.	$110.00
D3430	Retrograde filling - per root.	$43.00
D3450	Root amputation - per root.	$103.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$87.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$154.00
D3320	Endodontic therapy, bicuspid tooth.	$182.00
D3330	Endodontic therapy, molar.	$238.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$91.00
D3346	Retreatment of previous root canal therapy - anterior.	$192.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$221.00
D3348	Retreatment of previous root canal therapy - molar.	$275.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.

		Maximum Covered Expense
	• Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.	
SURGICAL ENDODONTICS		
D3355	Pulpal regeneration - initial visit.	$55.00
D3356	Pulpal regeneration - interim medication replacement.	$38.00
D3410	Apicoectomy - anterior.	$159.00
D3421	Apicoectomy - bicuspid (first root).	$183.00
D3425	Apicoectomy - molar (first root).	$198.00
D3426	Apicoectomy (each additional root).	$71.00
D3427	Periradicular surgery without apicoectomy.	$143.00
SURGICAL PERIODONTICS		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$100.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$50.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$138.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$69.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$253.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$127.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant.	$83.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant.	$62.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$41.00
D4270	Pedicle soft tissue graft procedure.	$186.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.	$230.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).	$111.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.	$197.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$230.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.	$198.00
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.	$79.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.	$230.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.	$89.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TYPE 2 PROCEDURES

		Maximum Covered Expense
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$52.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$26.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$38.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT		
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$31.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE		
D4910	Periodontal maintenance.	$32.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR		
D5510	Repair broken complete denture base.	$32.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$26.00
D5610	Repair resin denture base.	$31.00
D5620	Repair cast framework.	$37.00
D5630	Repair or replace broken clasp-per tooth.	$39.00
D5640	Replace broken teeth - per tooth.	$28.00
DENTURE RELINES		
D5730	Reline complete maxillary denture (chairside).	$58.00
D5731	Reline complete mandibular denture (chairside).	$58.00
D5740	Reline maxillary partial denture (chairside).	$52.00
D5741	Reline mandibular partial denture (chairside).	$53.00
D5750	Reline complete maxillary denture (laboratory).	$87.00
D5751	Reline complete mandibular denture (laboratory).	$85.00
D5760	Reline maxillary partial denture (laboratory).	$87.00
D5761	Reline mandibular partial denture (laboratory).	$87.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS		
D7111	Extraction, coronal remnants - deciduous tooth.	$28.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$28.00
SURGICAL EXTRACTIONS		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	$54.00
D7220	Removal of impacted tooth - soft tissue.	$67.00
D7230	Removal of impacted tooth - partially bony.	$89.00
D7240	Removal of impacted tooth - completely bony.	$104.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$119.00
D7250	Removal of residual tooth roots (cutting procedure).	$56.00
D7251	Coronectomy-intentional partial tooth removal.	$104.00
OTHER ORAL SURGERY		
D7260	Oroantral fistula closure.	$132.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7261	Primary closure of a sinus perforation.	$132.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$80.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$80.00
D7280	Exposure of an unerupted tooth.	$123.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$89.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$37.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$46.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$23.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$59.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$30.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$85.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$211.00
D7410	Excision of benign lesion up to 1.25 cm.	$84.00
D7411	Excision of benign lesion greater than 1.25 cm.	$108.00
D7412	Excision of benign lesion, complicated.	$119.00
D7413	Excision of malignant lesion up to 1.25 cm.	$114.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$83.00
D7415	Excision of malignant lesion, complicated.	$92.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$114.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$83.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$84.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$108.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$84.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$108.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$25.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$75.00
D7472	Removal of torus palatinus.	$75.00
D7473	Removal of torus mandibularis.	$75.00
D7485	Reduction of osseous tuberosity.	$122.00
D7490	Radical resection of maxilla or mandible.	$114.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$38.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$43.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$35.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$95.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$95.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$125.00
D7910	Suture of recent small wounds up to 5 cm.	$17.00
D7911	Complicated suture - up to 5 cm.	$19.00
D7912	Complicated suture - greater than 5 cm.	$27.00
D7960	Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.	$90.00
D7963	Frenuloplasty.	$113.00
D7970	Excision of hyperplastic tissue - per arch.	$70.00
D7972	Surgical reduction of fibrous tuberosity.	$111.00
D7980	Sialolithotomy.	$104.00
D7983	Closure of salivary fistula.	$33.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Incisional biopsy of oral tissue - hard (bone, tooth).	$113.00
D7286	Incisional biopsy of oral tissue - soft.	$61.00
D7287	Exfoliative cytological sample collection.	$30.00
D7288	Brush biopsy - transepithelial sample collection.	$30.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
PALLIATIVE		
D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$21.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV		
D9219	Evaluation for deep sedation or general anesthesia.	$16.00
D9223	Deep sedation/general anesthesia - each 15 minute increment.	$32.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment.	$27.00

GENERAL ANESTHESIA: D9223, D9243

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report are required. A maximum of four (D9223 or D9243) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES		
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$21.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$15.00
D9440	Office visit - after regularly scheduled hours.	$26.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$16.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT		
D9951	Occlusal adjustment - limited.	$20.00
D9952	Occlusal adjustment - complete.	$100.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS		
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	$18.00
D2951	Pin retention - per tooth, in addition to restoration.	$10.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$30.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$103.00
D2520	Inlay - metallic - two surfaces.	$123.00
D2530	Inlay - metallic - three or more surfaces.	$132.00
D2610	Inlay - porcelain/ceramic - one surface.	$114.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$123.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$135.00
D2650	Inlay - resin-based composite - one surface.	$118.00
D2651	Inlay - resin-based composite - two surfaces.	$116.00
D2652	Inlay - resin-based composite - three or more surfaces.	$120.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$133.00
D2543	Onlay - metallic - three surfaces.	$149.00
D2544	Onlay - metallic - four or more surfaces.	$155.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$133.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$149.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$154.00
D2662	Onlay - resin-based composite - two surfaces.	$125.00
D2663	Onlay - resin-based composite - three surfaces.	$129.00
D2664	Onlay - resin-based composite - four or more surfaces.	$137.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$58.00
D2712	Crown - 3/4 resin-based composite (indirect).	$145.00
D2720	Crown - resin with high noble metal.	$149.00
D2721	Crown - resin with predominantly base metal.	$114.00
D2722	Crown - resin with noble metal.	$139.00
D2740	Crown - porcelain/ceramic substrate.	$161.00
D2750	Crown - porcelain fused to high noble metal.	$156.00
D2751	Crown - porcelain fused to predominantly base metal.	$134.00
D2752	Crown - porcelain fused to noble metal.	$144.00
D2780	Crown - 3/4 cast high noble metal.	$149.00
D2781	Crown - 3/4 cast predominantly base metal.	$129.00
D2782	Crown - 3/4 cast noble metal.	$135.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$161.00
D2790	Crown - full cast high noble metal.	$149.00
D2791	Crown - full cast predominantly base metal.	$129.00
D2792	Crown - full cast noble metal.	$135.00
D2794	Crown - titanium.	$149.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins when required.	$32.00

CORE BUILDUP: D2950

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$51.00
D2954	Prefabricated post and core in addition to crown.	$43.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair necessitated by restorative material failure.	$26.00
D2981	Inlay repair necessitated by restorative material failure.	$21.00
D2982	Onlay repair necessitated by restorative material failure.	$21.00
D2983	Veneer repair necessitated by restorative material failure.	$21.00
D6980	Fixed partial denture repair necessitated by restorative material failure.	$29.00
D9120	Fixed partial denture sectioning.	$29.00

CROWN LENGTHENING

D4249	Clinical crown lengthening - hard tissue.	$92.00

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$166.00
D5120	Complete denture - mandibular.	$161.00
D5130	Immediate denture - maxillary.	$180.00
D5140	Immediate denture - mandibular.	$174.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$120.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$139.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$120.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$139.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$120.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$139.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$103.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$120.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$139.00
D5810	Interim complete denture (maxillary).	$73.00
D5811	Interim complete denture (mandibular).	$77.00
D5820	Interim partial denture (maxillary).	$65.00
D5821	Interim partial denture (mandibular).	$68.00
D5863	Overdenture - complete maxillary.	$166.00
D5864	Overdenture - partial maxillary.	$193.00
D5865	Overdenture - complete mandibular.	$166.00
D5866	Overdenture - partial mandibular.	$193.00
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary.	$166.00
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular.	$166.00
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary.	$193.00
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular.	$193.00
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary.	$166.00
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular.	$166.00
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary.	$193.00
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular.	$193.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6110, D6111, D6114, D6115

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$9.00
D5411	Adjust complete denture - mandibular.	$9.00
D5421	Adjust partial denture - maxillary.	$10.00
D5422	Adjust partial denture - mandibular.	$9.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	$21.00
D5660	Add clasp to existing partial denture-per tooth.	$25.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$61.00
D5711	Rebase complete mandibular denture.	$64.00
D5720	Rebase maxillary partial denture.	$58.00
D5721	Rebase mandibular partial denture.	$61.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	$17.00
D5851	Tissue conditioning, mandibular.	$18.00

PROSTHODONTICS - FIXED

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6058	Abutment supported porcelain/ceramic crown.	$139.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$151.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$151.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$139.00
D6062	Abutment supported cast metal crown (high noble metal).	$151.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$151.00
D6064	Abutment supported cast metal crown (noble metal).	$164.00
D6065	Implant supported porcelain/ceramic crown.	$139.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$151.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$151.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$139.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$151.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$151.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$139.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$151.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$151.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$164.00
D6075	Implant supported retainer for ceramic FPD.	$139.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$151.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$151.00
D6094	Abutment supported crown - (titanium).	$151.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$151.00
D6205	Pontic - indirect resin based composite.	$125.00
D6210	Pontic - cast high noble metal.	$151.00
D6211	Pontic - cast predominantly base metal.	$151.00
D6212	Pontic - cast noble metal.	$164.00
D6214	Pontic - titanium.	$151.00
D6240	Pontic - porcelain fused to high noble metal.	$151.00
D6241	Pontic - porcelain fused to predominantly base metal.	$151.00
D6242	Pontic - porcelain fused to noble metal.	$139.00
D6245	Pontic - porcelain/ceramic.	$139.00
D6250	Pontic - resin with high noble metal.	$151.00
D6251	Pontic - resin with predominantly base metal.	$139.00
D6252	Pontic - resin with noble metal.	$164.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$50.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$50.00
D6549	Resin retainer - for resin bonded fixed prosthesis.	$50.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces.	$123.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces.	$136.00
D6602	Retainer inlay - cast high noble metal, two surfaces.	$111.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces.	$122.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces.	$96.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces.	$105.00
D6606	Retainer inlay - cast noble metal, two surfaces.	$101.00
D6607	Retainer inlay - cast noble metal, three or more surfaces.	$111.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces.	$133.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces.	$147.00
D6610	Retainer onlay - cast high noble metal, two surfaces.	$122.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces.	$134.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces.	$105.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces.	$116.00
D6614	Retainer onlay - cast noble metal, two surfaces.	$111.00
D6615	Retainer onlay - cast noble metal, three or more surfaces.	$122.00
D6624	Retainer inlay - titanium.	$122.00
D6634	Retainer onlay - titanium.	$134.00
D6710	Retainer crown - indirect resin based composite.	$125.00
D6720	Retainer crown - resin with high noble metal.	$151.00
D6721	Retainer crown - resin with predominantly base metal.	$78.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6722	Retainer crown - resin with noble metal.	$126.00
D6740	Retainer crown - porcelain/ceramic.	$139.00
D6750	Retainer crown - porcelain fused to high noble metal.	$164.00
D6751	Retainer crown - porcelain fused to predominantly base metal.	$151.00
D6752	Retainer crown - porcelain fused to noble metal.	$139.00
D6780	Retainer crown - 3/4 cast high noble metal.	$164.00
D6781	Retainer crown - 3/4 cast predominantly base metal.	$151.00
D6782	Retainer crown - 3/4 cast noble metal.	$139.00
D6783	Retainer crown - 3/4 porcelain/ceramic.	$139.00
D6790	Retainer crown - full cast high noble metal.	$151.00
D6791	Retainer crown - full cast predominantly base metal.	$151.00
D6792	Retainer crown - full cast noble metal.	$139.00
D6794	Retainer crown - titanium.	$151.00
D6940	Stress breaker.	$42.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

        If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

        However, if the specific terms of a court decree establish a parent's responsibility for the child's Dental expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to $500.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than the applicable statute of limitations after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

GENERAL PROVISIONS (CONTINUED)

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to void the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	20%
Number of Members-	1,493

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

Dental Utilization Review Program. Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: STATE OF FLORIDA

whose main office address is: 4050 ESPLANADE WAY STE 215.6Y
TALLAHASSEE, FL 32399-7016

for Group Policy No. 10-350557

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

STATE OF FLORIDA

(Full or Corporate Name of Applicant)

Dated at_____By_____
(Signature and Title)

On_____, 20__ Witness_____
(To be signed by Resident Agent where required by law)

This copy is to Remain Attached to the Policy

Ameritas

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

CERTIFICATE
GROUP DENTAL INSURANCE

The Policyholder **STATE OF FLORIDA**

Policy Number **10-350557**

Insured Person **PAT Q. SPECIMEN**

Plan Effective Date **January 1, 2008**

Certificate Effective Date
Refer to Exceptions on 9070.

Plan Change Effective Date **January 1, 2011**

Class Number 1

Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

If you should have any questions regarding your coverage or claim payments, you may contact us toll-free at 877-721-2224.

JoAnn M Martin

President

Specimen

FLORIDA IMPORTANT INFORMATION TO INSUREDS

We are here to serve you . . .

You have the right to receive medically appropriate care in a timely and convenient manner and to be an active participant in any decision making regarding treatment, care and services provided to you or one of your family members who are covered under this plan.

In order to provide you the best possible service, it is important that you provide any necessary information to your provider that will facilitate effective medical care and that you cooperate with your provider(s) by keeping appointments and following recommended treatment.

Please review your certificate of coverage carefully so that you fully understand the benefits provided. If you have a question about your policy or if you need assistance with a problem, feel free to contact us at the number shown below.

If you have a grievance or complaint regarding an adverse decision, you may call us below or document your concerns in writing. Written documentation can be sent to the following:

Name:	Quality Control
Address:	P.O. Box 82657
	Lincoln, NE 68501-2657
Phone:	877-897-4328
Fax:	402-309-2579

The complaint will be carefully reviewed. If the initial claim was denied based on clinical necessity or paid as an alternate benefit, then a licensed provider will be involved in the review of the appeal. A written decision will be sent to the claimant within 15 business days following the receipt of the appeal.

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the Florida Office of Insurance Regulation with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact them, write or call:

Division of Consumer Services
Department of Financial Regulation
200 East Gaines Street
Tallahassee, FL 32399
(877) 693-5236 or (850) 413-3089

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	All Eligible Employees

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,000

In no event will expenses incurred for Type 1 Procedures count toward the Maximum Benefit.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. an Insured's spouse.

b. each child through the end of the calendar year in which they turn age 26, for whom the Insured or the Insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code.

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

   The child must be dependent upon the certificateholder for support and either living in the household of the certificateholder or is a full or part-time student.

c. each child age 26 or older who:

   i. is Totally Disabled due to mental or physical reasons; and

   ii. becomes Totally Disabled while insured as a dependent under b. above.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider." The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any full time active employee working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. Coverage for a newborn child of a covered dependent other than a spouse will stop on the date the child attains eighteen months of age.

An adopted child, foster child and other child in court-ordered custody placed pursuant to Chapter 63 will be covered from the date of placement in the Insured's residence. A newborn adopted child will be covered from the date of birth if the Insured has agreed in writing to adopt the child prior to its birth and the child is ultimately placed in the Insured's residence.

Coverage for a newborn child shall consist of coverage for all covered Dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, including the necessary care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured may give us written notice within 61 days of the date of birth or placement of a dependent child to start coverage. If timely notice is given, we will not charge an additional premium for the 61-day notice period. If timely notice is not given, we will charge the applicable additional premium from the date of birth or placement for an adopted child. We will not deny coverage for a child due to the failure of the Insured to notify us within 60 days of the child's birth or placement.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any full time active employee working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This policy is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1. A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. 1 on 9219. (There is NO "open enrollment" under this policy.)

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become members after the Plan Effective Date of the policy, qualification will occur the first of the month following the collection of one full month's premium.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he

or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

i. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

ii. the person is considered a Member or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. For those Dependents whose coverage terminates because they no longer meet the definition of a Dependent as a result of a limiting age (See "Definitions"), insurance will continue in force throughout the remainder of that year but will automatically terminate December 31 of the year following the attainment of that limiting age.

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as covered under your plan.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. The policy provides an extension of benefits if all the following conditions are met:

1. Only dental procedures, as defined within the Table of Dental Procedures, are eligible for this extension, **except** for the dental procedures performed for routine examinations, cleanings, radiographic images and sealants.

2. The dental procedures must have been performed within 90 days after an Insured's insurance terminates due to discontinuance of the policy.

3. The course of dental treatment or dental procedures must have been recommended to the Insured by a provider in writing and commenced while insurance was in effect for the Insured.

4. Any dental procedures performed in the 90-day extension period are subject to the same policy provisions that would have applied had the Insured's insurance still been in effect.

5. To be eligible for this extension, the Insured is not required to be totally disabled.

When all the foregoing conditions have been met, dental procedures performed after the insurance on an Insured terminates will be considered as if the Insured's insurance was still in effect.

This extension will terminate on the earlier of:

1. the end of the 90-day extension period; and

2. the date the Insured is covered under another group health plan providing similar dental coverage. However, the extension will not terminate if the succeeding plan excludes the dental procedures eligible for extension with a waiting period.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

2. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is paid benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not. However, terrorism, or any act of terrorism, will not be excluded.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Ø Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.

- Ø Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

- Ø Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review. Examples of procedures which may be subject to Alternate Benefits are crowns, inlays, onlays, fixed partial dentures, composite restorations, and overdentures. Examples of procedures which may be subject to plan payments based on consultant review are services related to oral maxillofacial surgery, fixed partial dentures, periodontics, and endodontics.

- Ø Reference to "traumatic injury" under this plan is defined as any injury caused by an object or a force other than bruxism (grinding of teeth).

- Ø Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.

- Ø B/R means By Report.

- Ø We may request radiographs, periodontal charting, surgical notes, narratives, photos and/or a patient's records on any procedure for our dental consultants to review. Commonly reviewed procedures include: Periodontic procedures, Oral Maxillofacial Surgical procedures, Implants, Crowns, Inlays, Onlays, Core Build-Ups, Fixed Partial Dentures, Post and Cores, Veneers, Endodontic Retreatment, and Apexification/Recalcification procedures.

- Ø We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.

- Ø A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$14.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$11.00
D0150	Comprehensive oral evaluation - new or established patient.	$22.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$22.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC		
D0210	Intraoral - complete series of radiographic images.	$45.00
D0330	Panoramic radiographic image.	$36.00

COMPLETE SERIES/PANORAMIC: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first radiographic image.	$8.00
D0230	Intraoral - periapical each additional radiographic image.	$6.00
D0240	Intraoral - occlusal radiographic image.	$11.00
D0250	Extraoral - first radiographic image.	$15.00
D0260	Extraoral - each additional radiographic image.	$11.00

PERIAPICAL: D0220, D0230

- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS		
D0270	Bitewing - single radiographic image.	$7.00
D0272	Bitewings - two radiographic images.	$13.00
D0273	Bitewings - three radiographic images.	$15.00
D0274	Bitewings - four radiographic images.	$20.00
D0277	Vertical bitewings - 7 to 8 radiographic images.	$30.00

BITEWINGS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$30.00
D1120	Prophylaxis - child.	$21.00

TYPE 1 PROCEDURES

		Maximum Covered Expense
D1206	Topical application of fluoride varnish.	$11.00
D1208	Topical application of fluoride.	$11.00

FLUORIDE: D1206, D1208

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$17.00
D1352	Preventive resin restoration in a moderate to high caries risk patient-permanent.	$17.00

SEALANT: D1351, D1352

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$106.00
D1515	Space maintainer - fixed - bilateral.	$174.00
D1520	Space maintainer - removable - unilateral.	$166.00
D1525	Space maintainer - removable - bilateral.	$202.00
D1550	Re-cementation of space maintainer.	$22.00
D1555	Removal of fixed space maintainer.	$30.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$160.00
D8220	Fixed appliance therapy.	$160.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$15.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$15.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$18.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$35.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$35.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$25.00
D2150	Amalgam - two surfaces, primary or permanent.	$32.00
D2160	Amalgam - three surfaces, primary or permanent.	$38.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$46.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$30.00
D2331	Resin-based composite - two surfaces, anterior.	$38.00
D2332	Resin-based composite - three surfaces, anterior.	$48.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$53.00
D2391	Resin-based composite - one surface, posterior.	$33.00
D2392	Resin-based composite - two surfaces, posterior.	$42.00
D2393	Resin-based composite - three surfaces, posterior.	$53.00
D2394	Resin-based composite - four or more surfaces, posterior.	$58.00
D2410	Gold foil - one surface.	$25.00
D2420	Gold foil - two surfaces.	$32.00
D2430	Gold foil - three surfaces.	$38.00
D2990	Resin infiltration of incipient smooth surface lesions.	$30.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)		
D2390	Resin-based composite crown, anterior.	$65.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth.	$60.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2930	Prefabricated stainless steel crown - primary tooth.	$54.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$58.00
D2932	Prefabricated resin crown.	$65.00
D2933	Prefabricated stainless steel crown with resin window.	$65.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$65.00

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$20.00
D2915	Recement cast or prefabricated post and core.	$10.00
D2920	Recement crown.	$20.00
D2921	Reattachment of tooth fragment, incisal edge or cusp.	$48.00
D6092	Recement implant/abutment supported crown.	$20.00
D6093	Recement implant/abutment supported fixed partial denture.	$20.00
D6930	Recement fixed partial denture.	$27.00

SEDATIVE FILLING

D2940	Protective restoration.	$18.00
D2941	Interim therapeutic restoration - primary dentition.	$14.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$34.00
D3221	Pulpal debridement, primary and permanent teeth.	$34.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$51.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$45.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$39.00
D3333	Internal root repair of perforation defects.	$55.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).	$55.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).	$38.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$110.00
D3357	Pulpal regeneration - completion of treatment.	$110.00
D3430	Retrograde filling - per root.	$43.00
D3450	Root amputation - per root.	$103.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$87.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$154.00
D3320	Endodontic therapy, bicuspid tooth.	$182.00
D3330	Endodontic therapy, molar.	$238.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$91.00
D3346	Retreatment of previous root canal therapy - anterior.	$192.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$221.00
D3348	Retreatment of previous root canal therapy - molar.	$275.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.

		Maximum Covered Expense
	• Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.	
SURGICAL ENDODONTICS		
D3355	Pulpal regeneration - initial visit.	$55.00
D3356	Pulpal regeneration - interim medication replacement.	$38.00
D3410	Apicoectomy - anterior.	$159.00
D3421	Apicoectomy - bicuspid (first root).	$183.00
D3425	Apicoectomy - molar (first root).	$198.00
D3426	Apicoectomy (each additional root).	$71.00
D3427	Periradicular surgery without apicoectomy.	$143.00
SURGICAL PERIODONTICS		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$100.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$50.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$138.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$69.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$253.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$127.00
D4263	Bone replacement graft - first site in quadrant.	$83.00
D4264	Bone replacement graft - each additional site in quadrant.	$62.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$41.00
D4270	Pedicle soft tissue graft procedure.	$186.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$230.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$111.00
D4275	Soft tissue allograft.	$197.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$230.00
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in a graft.	$198.00
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site.	$79.00
	BONE GRAFTS: D4263, D4264, D4265	
	• Each quadrant is limited to 1 of each of these procedures per 3 year(s).	
	• Coverage is limited to treatment of periodontal disease.	
	GINGIVECTOMY: D4210, D4211	
	• Each quadrant is limited to 1 of each of these procedures per 3 year(s).	
	• Coverage is limited to treatment of periodontal disease.	
	OSSEOUS SURGERY: D4240, D4241, D4260, D4261	
	• Each quadrant is limited to 1 of each of these procedures per 3 year(s).	
	• Coverage is limited to treatment of periodontal disease.	
	TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278	
	• Each quadrant is limited to 2 of any of these procedures per 3 year(s).	
	• Coverage is limited to treatment of periodontal disease.	
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$52.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$26.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$38.00
	CHEMOTHERAPEUTIC AGENTS: D4381	
	• Each quadrant is limited to 2 of any of these procedures per 2 year(s).	

TYPE 2 PROCEDURES

		Maximum Covered Expense
	PERIODONTAL SCALING & ROOT PLANING: D4341, D4342	
	• Each quadrant is limited to 1 of each of these procedures per 2 year(s).	
	FULL MOUTH DEBRIDEMENT	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$31.00
	FULL MOUTH DEBRIDEMENT: D4355	
	• Coverage is limited to 1 of any of these procedures per 5 year(s).	
	PERIODONTAL MAINTENANCE	
D4910	Periodontal maintenance.	$32.00
	PERIODONTAL MAINTENANCE: D4910	
	• Coverage is limited to 2 of any of these procedures per 1 benefit period.	
	• D1110, D1120, also contribute(s) to this limitation.	
	• Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.	
	DENTURE REPAIR	
D5510	Repair broken complete denture base.	$32.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$26.00
D5610	Repair resin denture base.	$31.00
D5620	Repair cast framework.	$37.00
D5630	Repair or replace broken clasp.	$39.00
D5640	Replace broken teeth - per tooth.	$28.00
	DENTURE RELINES	
D5730	Reline complete maxillary denture (chairside).	$58.00
D5731	Reline complete mandibular denture (chairside).	$58.00
D5740	Reline maxillary partial denture (chairside).	$52.00
D5741	Reline mandibular partial denture (chairside).	$53.00
D5750	Reline complete maxillary denture (laboratory).	$87.00
D5751	Reline complete mandibular denture (laboratory).	$85.00
D5760	Reline maxillary partial denture (laboratory).	$87.00
D5761	Reline mandibular partial denture (laboratory).	$87.00
	DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	
	• Coverage is limited to service dates more than 6 months after placement date.	
	NON-SURGICAL EXTRACTIONS	
D7111	Extraction, coronal remnants - deciduous tooth.	$28.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$28.00
	SURGICAL EXTRACTIONS	
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	$54.00
D7220	Removal of impacted tooth - soft tissue.	$67.00
D7230	Removal of impacted tooth - partially bony.	$89.00
D7240	Removal of impacted tooth - completely bony.	$104.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$119.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$56.00
D7251	Coronectomy-intentional partial tooth removal.	$104.00
	OTHER ORAL SURGERY	
D7260	Oroantral fistula closure.	$132.00
D7261	Primary closure of a sinus perforation.	$132.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$80.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$80.00
D7280	Surgical access of an unerupted tooth.	$123.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$89.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$37.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$46.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$23.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$59.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$30.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$85.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$211.00
D7410	Excision of benign lesion up to 1.25 cm.	$84.00
D7411	Excision of benign lesion greater than 1.25 cm.	$108.00
D7412	Excision of benign lesion, complicated.	$119.00
D7413	Excision of malignant lesion up to 1.25 cm.	$114.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$83.00
D7415	Excision of malignant lesion, complicated.	$92.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$114.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$83.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$84.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$108.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$84.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$108.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$25.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$75.00
D7472	Removal of torus palatinus.	$75.00
D7473	Removal of torus mandibularis.	$75.00
D7485	Surgical reduction of osseous tuberosity.	$122.00
D7490	Radical resection of maxilla or mandible.	$114.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$38.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$43.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$35.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$95.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$95.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$125.00
D7910	Suture of recent small wounds up to 5 cm.	$17.00
D7911	Complicated suture - up to 5 cm.	$19.00
D7912	Complicated suture - greater than 5 cm.	$27.00
D7960	Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.	$90.00
D7963	Frenuloplasty.	$113.00
D7970	Excision of hyperplastic tissue - per arch.	$70.00
D7972	Surgical reduction of fibrous tuberosity.	$111.00
D7980	Sialolithotomy.	$104.00
D7983	Closure of salivary fistula.	$33.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$113.00
D7286	Biopsy of oral tissue - soft.	$61.00
D7287	Exfoliative cytological sample collection.	$30.00
D7288	Brush biopsy - transepithelial sample collection.	$30.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$21.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$80.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$26.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$53.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$13.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$21.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$15.00
D9440	Office visit - after regularly scheduled hours.	$26.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$16.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$20.00
D9952	Occlusal adjustment - complete.	$100.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	$18.00
D2951	Pin retention - per tooth, in addition to restoration.	$10.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$30.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$103.00
D2520	Inlay - metallic - two surfaces.	$123.00
D2530	Inlay - metallic - three or more surfaces.	$132.00
D2610	Inlay - porcelain/ceramic - one surface.	$114.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$123.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$135.00
D2650	Inlay - resin-based composite - one surface.	$118.00
D2651	Inlay - resin-based composite - two surfaces.	$116.00
D2652	Inlay - resin-based composite - three or more surfaces.	$120.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$133.00
D2543	Onlay - metallic - three surfaces.	$149.00
D2544	Onlay - metallic - four or more surfaces.	$155.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$133.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$149.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$154.00
D2662	Onlay - resin-based composite - two surfaces.	$125.00
D2663	Onlay - resin-based composite - three surfaces.	$129.00
D2664	Onlay - resin-based composite - four or more surfaces.	$137.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$58.00
D2712	Crown - 3/4 resin-based composite (indirect).	$145.00
D2720	Crown - resin with high noble metal.	$149.00
D2721	Crown - resin with predominantly base metal.	$114.00
D2722	Crown - resin with noble metal.	$139.00
D2740	Crown - porcelain/ceramic substrate.	$161.00
D2750	Crown - porcelain fused to high noble metal.	$156.00
D2751	Crown - porcelain fused to predominantly base metal.	$134.00
D2752	Crown - porcelain fused to noble metal.	$144.00
D2780	Crown - 3/4 cast high noble metal.	$149.00
D2781	Crown - 3/4 cast predominantly base metal.	$129.00
D2782	Crown - 3/4 cast noble metal.	$135.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$161.00
D2790	Crown - full cast high noble metal.	$149.00
D2791	Crown - full cast predominantly base metal.	$129.00
D2792	Crown - full cast noble metal.	$135.00
D2794	Crown - titanium.	$149.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins when required.	$32.00

CORE BUILDUP: D2950

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$51.00
D2954	Prefabricated post and core in addition to crown.	$43.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair necessitated by restorative material failure.	$26.00
D2981	Inlay repair necessitated by restorative material failure.	$21.00
D2982	Onlay repair necessitated by restorative material failure.	$21.00
D2983	Veneer repair necessitated by restorative material failure.	$21.00
D6980	Fixed partial denture repair necessitated by restorative material failure.	$29.00
D9120	Fixed partial denture sectioning.	$29.00

CROWN LENGTHENING

D4249	Clinical crown lengthening - hard tissue.	$92.00

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$166.00
D5120	Complete denture - mandibular.	$161.00
D5130	Immediate denture - maxillary.	$180.00
D5140	Immediate denture - mandibular.	$174.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$120.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$139.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$193.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$120.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$139.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$103.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$120.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$139.00
D5810	Interim complete denture (maxillary).	$73.00
D5811	Interim complete denture (mandibular).	$77.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5820	Interim partial denture (maxillary).	$65.00
D5821	Interim partial denture (mandibular).	$68.00
D5863	Overdenture - complete maxillary.	$166.00
D5864	Overdenture - partial maxillary.	$193.00
D5865	Overdenture - complete mandibular.	$166.00
D5866	Overdenture - partial mandibular.	$193.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$166.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$193.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$166.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$193.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6053 and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6054 and D6079 are considered at an alternate benefit of D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$9.00
D5411	Adjust complete denture - mandibular.	$9.00
D5421	Adjust partial denture - maxillary.	$10.00
D5422	Adjust partial denture - mandibular.	$9.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	$21.00
D5660	Add clasp to existing partial denture.	$25.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$61.00
D5711	Rebase complete mandibular denture.	$64.00
D5720	Rebase maxillary partial denture.	$58.00
D5721	Rebase mandibular partial denture.	$61.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	$17.00
D5851	Tissue conditioning, mandibular.	$18.00

PROSTHODONTICS - FIXED

D6058	Abutment supported porcelain/ceramic crown.	$139.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$151.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$151.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$139.00
D6062	Abutment supported cast metal crown (high noble metal).	$151.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$151.00
D6064	Abutment supported cast metal crown (noble metal).	$164.00
D6065	Implant supported porcelain/ceramic crown.	$139.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$151.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$151.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$139.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$151.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$151.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$139.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$151.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$151.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$164.00
D6075	Implant supported retainer for ceramic FPD.	$139.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$151.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$151.00
D6094	Abutment supported crown - (titanium).	$151.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$151.00
D6205	Pontic - indirect resin based composite.	$125.00
D6210	Pontic - cast high noble metal.	$151.00
D6211	Pontic - cast predominantly base metal.	$151.00
D6212	Pontic - cast noble metal.	$164.00
D6214	Pontic - titanium.	$151.00
D6240	Pontic - porcelain fused to high noble metal.	$151.00
D6241	Pontic - porcelain fused to predominantly base metal.	$151.00
D6242	Pontic - porcelain fused to noble metal.	$139.00
D6245	Pontic - porcelain/ceramic.	$139.00
D6250	Pontic - resin with high noble metal.	$151.00
D6251	Pontic - resin with predominantly base metal.	$139.00
D6252	Pontic - resin with noble metal.	$164.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$50.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$50.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$123.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$136.00
D6602	Inlay - cast high noble metal, two surfaces.	$111.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$122.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$96.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$105.00
D6606	Inlay - cast noble metal, two surfaces.	$101.00
D6607	Inlay - cast noble metal, three or more surfaces.	$111.00
D6608	Onlay - porcelain/ceramic, two surfaces.	$133.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$147.00
D6610	Onlay - cast high noble metal, two surfaces.	$122.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$134.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$105.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$116.00
D6614	Onlay - cast noble metal, two surfaces.	$111.00
D6615	Onlay - cast noble metal, three or more surfaces.	$122.00
D6624	Inlay - titanium.	$122.00
D6634	Onlay - titanium.	$134.00
D6710	Crown - indirect resin based composite.	$125.00
D6720	Crown - resin with high noble metal.	$151.00
D6721	Crown - resin with predominantly base metal.	$78.00
D6722	Crown - resin with noble metal.	$126.00
D6740	Crown - porcelain/ceramic.	$139.00
D6750	Crown - porcelain fused to high noble metal.	$164.00
D6751	Crown - porcelain fused to predominantly base metal.	$151.00
D6752	Crown - porcelain fused to noble metal.	$139.00
D6780	Crown - 3/4 cast high noble metal.	$164.00
D6781	Crown - 3/4 cast predominantly base metal.	$151.00
D6782	Crown - 3/4 cast noble metal.	$139.00
D6783	Crown - 3/4 porcelain/ceramic.	$139.00
D6790	Crown - full cast high noble metal.	$151.00
D6791	Crown - full cast predominantly base metal.	$151.00
D6792	Crown - full cast noble metal.	$139.00
D6794	Crown - titanium.	$151.00
D6940	Stress breaker.	$42.00

TYPE 3 PROCEDURES

Maximum Covered Expense

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

        If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

        However, if the specific terms of a court decree establish a parent's responsibility for the child's Dental expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive due proof.

If benefits are contested or denied, we will notify the Insured, in writing, which benefits are contested or denied within 45 days of when we received due proof. We will pay or deny any balance remaining on benefits for a claim within 60 days upon receipt of any additional information requested from the Insured. In no event will we hold a claim without paying or denying benefits any later than 120 days.

Payment is considered to be made on the date a draft or other valid instrument is placed in the United States mail in a properly addressed post paid envelope or, if not so posted, on the date of delivery.

We will pay interest at the rate of 10 percent per year on overdue payments on benefits for valid claims.

We will investigate any claim of improper billing of a claim by a Provider upon written notification by an Insured. We will determine if the Insured was properly billed for only those procedures that the Insured actually received. If we determine that the Insured was improperly billed, we will notify the Insured and the provider of our findings and will reduce the amount of payment by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, we will pay the Insured 20 percent of the reduction up to $500.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than the applicable statute of limitations after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. Eligibility and Benefits Provided Under the Group Policy

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

If you have any questions about your benefits or concerns about our services related to this Group Policy, you may call Customer Service Toll Free at 1-877-721-2224.

B. Qualified Medical Child Support Order ("QMCSO")

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

C. Termination Of The Group Policy

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Ameritas Life Insurance Corp. It will terminate automatically if the Policyholder fails to pay the required premium. Ameritas Life Insurance Corp. may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Ameritas Life Insurance Corp. believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Ameritas Life Insurance Corp. may also terminate the Group Policy on any Premium Due Date for any reason by providing a 45-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Ameritas Life Insurance Corp. executive officer.

D. Claims For Benefits

Claims procedures are furnished automatically, without charge, as a separate document.

E. Continuation of Coverage Provisions (COBRA)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

i. Definitions For This Section

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);

2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);

3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);

6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);

7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

1. The date on which Insurance would otherwise end; and

2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:

1. The Member’s Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;

2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and

3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:

a. The date of the Qualifying Event; or
b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

   a. The date of the disability determination;

   b. The date of the Qualifying Event; or

   c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:

   a. The date of the Qualifying Event; or

   b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.

6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

   Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

   Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

   If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up

to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. Premium Requirements

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;

2. 31 days after the date the last period ends for which a required premium payment was made;

3. The last day of the COBRA continuation period.

4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group Dental policy and (b) not subject to any preexisting condition limitation in that policy.

F. Your Rights under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Rights
If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C.

20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration.

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

Dental Utilization Review Program. Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us.

Ameritas Privacy Office Contact Information: To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-800-487-5553 and request the appropriate form. Please direct any questions about this Notice or requests for further information, or to file a complaint: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 81889, Lincoln, NE 68501-1889, or e-mail us at privacy@ameritas.com.

YOUR RIGHTS
YOU HAVE THE RIGHT TO:

Get a copy of your claims records

- You can ask to see or get a copy of your claims records we maintain about you. Ask us how to do this.
- We will provide a copy or a summary of your claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Correct your claims records

- You can ask us to correct your claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

Request confidential communication

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit the information we share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect payment for your care.

Get a list of those with whom we've shared your information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you believe your privacy rights have been violated

- You can complain if you feel we have violated your rights by contacting us using the contact information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa /complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **Answer coverage questions from your family and friends**.
  At your directions we will share information with your family, close friends, or others involved in payment for your care.
- **Share information in a disaster relief situation**.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will not share your personal information for marketing purposes or sell your personal information unless you give us your written permission to do so.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

  Example: We use health information about you to develop better coverage and service offerings for our insured members, including you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with other health benefit plans that you might also be covered by to coordinate payment for your health services.

Administer your health plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways– usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa /understanding/ consumers/index.html.

Help with public health and safety issues – We can share your health information in certain situations such as to help prevent disease or to report suspected abuse, neglect or domestic violence.

Comply with the law – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests – We can share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.

Respond to lawsuits and legal actions – We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa /understanding/consumers/noticepp.html.

This Revised Notice is effective 9/23/13.

To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-877-721-2224 and request the appropriate form.

ASSURANT Employee Benefits®

Assurant. On your terms.®

Offering State of Florida employees...
2014 benefit options

NO CHANGE TO YOUR PREMIUMS FOR 2014!

Two dental plans to choose from — *Look at these features!*

Indemnity with PPO Insured Plan/ Freedom Advance (People First Plan Code: 4074)

- Freedom to choose any dentist or specialist
- In- and out-of-network coinsurance is the same; no penalty for using out-of-network dentist
- NEW! Calendar year deductible (waived for Type I): $50/individual and $100/per family, in- or out-of-network
- NEW! Major services (Type III) covered at 50% in the first year with no waiting periods
- Access to over 6,200 unique dentists in Florida (and more than 100,000 nationwide) offering up to 30% off their usual fees
- Coverage for ***up to 4 cleanings per year***
- 100% coverage for preventive services such as cleanings and X-rays
- Coverage for composite resins (white fillings) on back teeth
- Vision Discount Program included

Learn more on page 2

Prepaid 225 with Ortho Copays Plan (People First Plan Code: 4025)

- "No charge" for 35 procedures including oral exams, x-rays, routine cleanings, flouride treatments, and sealants; 250+ procedures covered by set copayments
- No deductibles or claim forms, annual benefit maximum, or waiting periods
- Pre-existing dental conditions are covered
- Each family member may choose their own Plan dentist
- 30 common specialty procedures provided by member's selected Plan dentist or Plan Specialist for same copayment
- An implant benefit
- Set copayments for child and adult orthodontic treatments
- Vision Discount Program included

Learn more on page 4

Assurant Employee Benefits is the brand name for insurance products underwritten and prepaid products provided by Union Security Insurance Company. Plans contain limitations, exclusions, reductions and restrictions. Contact us for costs and complete details.

We make it simple to enroll with two easy options:

- Visit https://peoplefirst.myflorida.com, or
- Call People First at 866.663.4735

RFP No.: DMS 16/17-016
Attachment 6

Introducing your State of Florida Indemnity with PPO Insured Plan - Freedom Advance℠

How the plan works

Coverage includes dental and vision benefits through payroll deduction. This dental insurance plan provides a variety of benefits and allows you and your family to use any dentist or specialist you choose. Benefits are paid after any applicable deductible has been met, up to the annual maximum for each covered family member.

Claim payments may be paid direct to you or you may assign them to your dentist, whichever you prefer. Freedom Advance offers the Assurant® Dental Network[1] PPO (Preferred Provider Organization) that provides a variety of cost saving features when you see an Assurant Dental Network provider. With Assurant Dental Network you can save money every time you visit the dentist. All the dentists who participate in the Assurant Dental Network PPO have agreed to discount their fees by up to 30%. Here is a sample cost savings example:

	Visit to Network Dentist	Visit to Non-Network Dentist
Crown	$862	$862
Minus PPO Discount	30%	NA
Allowed Amount	$603	$862
Insurance pays 50%	$302	$431
You pay	$301	$431
Savings from using an Assurant Dental Network provider	$130	NA

[1]Assurant® Dental Network, Assurant Employee Benefits' dental network name, includes dentists contracted with Dental Health Alliance, L.L.C.® (D.H.A.®) and dentists under access arrangements with other dental networks.

**Savings may differ in cases where deductibles apply.*

How to find an Assurant Dental Network PPO dentist?

It's easy to locate participating general dentists and specialists in your area. You have these options:

1. **Visit** www.assurantemployeebenefits.com/STofFL or use our mobile app Benefit Tools
   - Choose the search method you prefer to search for an Assurant Dental Network provider
   - Enter in your search criteria and a listing of participating dentists will be provided
2. **Call** Assurant Employee Benefits at 800.442.7742 for assistance in locating an Assurant Dental Network provider.
3. If your dentist is not a participating provider you may **nominate** them at www.assurantemployeebenefits.com under "For Members" then "Find a Dentist" for consideration into the network.

Lifetime of Smiles®

Freedom Advance includes Lifetime of Smiles®, our oral health program dedicated to improving the smiles of our members for a lifetime with the following features!

- **Four cleanings per year** to help prevent gum disease[2]
- **Posterior tooth-colored fillings** preferred by many dentists and their patients
- **Genetic testing** to help identify individuals who are at genetic risk for gum disease
- **Periochips** to control bacteria and reduce the size of periodontal pockets
- **Online Dental Health Center** a trusted resource that offers members the most up-to-date information available on preventive dental care

Plan rates (People First Plan Code: 4074)		
Payroll Deduction	**Bi-Weekly (24)**	**Monthly**
Employee	$20.74	$41.48
Employee/Spouse	$39.82	$79.63
Employee/Child(ren)	$46.92	$93.84
Employee/Family	$62.07	$124.14

[2]Dental prophylaxis cleaning is limited to 1 time in any 6 month period and periodontal maintenance procedure is limited to 1 in any 3 month period. Total number of combined dental prophylaxis cleanings and periodontal maintenance procedures cannot exceed 4 in a 12 month period.

Introducing your State of Florida Indemnity with PPO Insured Plan - Freedom Advance℠

Schedule of Benefits

CALENDAR YEAR DEDUCTIBLE
(waived for Type I - Diagnostic and Preventive Services)
In-or Out-of-Network - $50 per person; $100 per family

CALENDAR YEAR MAXIMUM
In-or Out-of-Network - $1,500 per person

TYPE I - DIAGNOSTIC & PREVENTIVE SERVICES
In-or Out-of-Network - 100%

- Routine Oral Examinations - once every 6 months in a row
- Routine Dental Cleanings - once every 6 months (Frequencies combined with Periodontal Maintenance)
- Fluoride Treatment - once every 12 months in a row *Only for children under age 14*
- Sealants - No more than once per tooth per person, only for permanent molar teeth *Only for children under age 16*
- Bitewing X-Rays - once every 12 months

TYPE II - BASIC SERVICES
In-or Out-of-Network - 80%

- X-Rays:
  - Complete Series - once every 60 months
  - Panoramic - once every 60 months (may also be payable in connection with the removal of impacted teeth)
  - Other X-Rays (See Certificate of Insurance)
- New Fillings, Replacement Fillings - once every 24 months per Filling
- Simple Extractions, Removal of Exposed Roots, Incision and Drainage
- Certain Lab Tests, Pain Treatment, Therapeutic Drug Injections

TYPE III - MAJOR SERVICES
In-or Out-of-Network - 50%

- Endodontics (includes root canal therapy)
- Endodontic retreatment (covered after 24 months have passed from initial treatment)
- Complex Oral Surgery: General Anesthesia and IV Sedation when medically required for such Surgery
- Minor Gum Disease Treatment: (Minor Periodontics)
  - Provisional Splinting, Occlusal Adjustments - once every 12 months
  - Scaling and Root Planing - once every 24 months per area
  - Periodontal Maintenance - once every 6 months (Frequencies combined with Routine Dental Cleanings)
- Major Gum Disease Treatment: (Major Periodontics)
  - Gingivectomy, Osseous Surgery, other major periodontic procedures - once every 36 months per area
- Crowns, Initial Placement, Replacement and Maintenance of Inlays, Onlays, Fixed Partial Dentures (Bridges), and Partial and Complete Dentures

TYPE IV - ORTHODONTIC SERVICES
Only for dependent children under age 19; 12 month waiting period
In-or Out-of-Network - 50%

- Limited Orthodontic Treatment
- Interceptive Orthodontic Treatment
- Comprehensive Orthodontic Treatment
- Minor Treatment to control harmful habits

Other Policy Provisions

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care. If the cost of a proposed Dental Treatment Plan exceeds $300, it should be submitted for an estimate of benefits payable.

This is a brief description only. It is not a Certificate of Coverage. Please see the Group Policy, which alone determines all rights, benefits, and applicable limitations, exclusions and restrictions.

Introducing your State of Florida Prepaid Plan – Prepaid 225 with Ortho Copayments

How the plan works

Coverage includes dental and vision benefits through payroll deduction. With the Prepaid Dental Series 225 you pay reduced fees called "copayments" for dental services provided by a network provider (Plan Dentist). At the time of enrollment, you must choose a Plan Dentist for each family member from the list of participating general dentists. You can change your Plan Dentist as frequently as every month with a simple call to customer service. Contact Assurant Employee Benefits by the 10th of the month for the change to be effective the first of the following month. Once you have selected a primary dentist, you will be included on your dentist's monthly member roster and you can contact the office to make your dental appointments. You may see a specialist without a referral from your general dentist. Please see page 4 for information on how to obtain services from a Plan Specialist.

Visit www.assurantemployeebenefits.com/STofFL for a list of participating providers and complete plan information including the covered services.

Your prepaid dental plan is simple to use when you follow these steps:

- Verify with your Plan Dentist that you are on their roster before making a dental appointment.
- Call early for routine dental care for the best availability of appointment times.
- Be familiar with your copayment schedule to determine your costs for dental services.
- Discuss concerns regarding proposed treatments with your Plan Dentist.
- Contact customer service at 800.443.2995 for assistance with selecting or changing your Plan Dentist.
- Remember your dental costs will not be covered if you choose to see a dentist other than your selected Plan Dentist.

How do I find a Prepaid Plan Dentist?

There are two steps in finding and selecting a prepaid plan dentist:

1. Visit the Assurant Employee Benefits' State of Florida web site at www.assurantemployeebenefits.com/STofFL or use our mobile app Benefit Tools. You will be able to customize the provider search based on your input. Choose Prepaid Dental Series (PPD Series) to search for a participating dentist.

2. You must select a plan provider and notify Assurant Employee Benefits of your Plan Dentist selection before you can make an appointment to receive your dental care. See the back cover of this booklet for the options you have for providing your dentist selection information to Assurant Employee Benefits.

The Prepaid plan is a network-based dental program and a great way to receive your dental care!

Prepaid Customer Service 800.443.2995
State of Florida web site to locate participating dentist and plan information
www.assurantemployeebenefits.com/STofFL

Plan prepayment fees (People First Plan Code: 4025)

Payroll Deduction	Bi-Weekly (24)	Monthly
Employee	$7.47	$14.93
Employee/Spouse	$12.59	$25.17
Employee/Child(ren)	$16.63	$33.26
Employee/Family	$21.77	$43.54

PREPAID 225 with Ortho Copayments Plan
Partial Copayment Schedule

1. Plan Dentist Services

The dental services listed in the following schedule are covered when provided by the Member's selected Plan Dentist. If Member requires dental specialty services that cannot be provided by selected Plan Dentist, Member may obtain from a Plan Specialty Dentist the services marked as dental specialty services (S) in this Section 1. No referral from Member's selected Plan Dentist is needed to receive services from a Plan Specialty Dentist. The Member will be responsible for paying the amount listed in the "Member Copayment" column (plus any applicable lab fees (*)) at the time the service is received, or in accordance with the Plan Provider's billing procedures.

Dental services obtained from a Plan Specialty Dentist that are not listed and marked as dental specialty services (S) in this Section 1 below will be provided to Member at reduced charges. A 15% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from a Plan Specialty Dentist whose practice is limited to endodontics. A 25% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from any other Plan Specialty Dentist (including, but not limited to, a Plan Specialty Dentist whose practice is orthodontics). Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

To fully understand the benefits, exclusions and limitations of this plan, the Member should consult the Evidence of Coverage. The Plan Provider is permitted to charge the member for any missed appointments if the Member fails to give at least 24 hours notice. The charge may not exceed $25.00.

Services marked with a single asterisk (*) below also require separate payment of laboratory charges. The laboratory charges must be paid to the Plan Provider in addition to any applicable copayment for the service.

Payment for each service of a Non-Plan Dentist (at that dentist's normal retail charge) is the responsibility of the Member, except for Plan Benefits for covered dental Emergency Services.

This is a partial copayment list. **This is not the full copayment schedule.** The full copayment schedule is available on the website at www.assurantemployeebenefits.com/STof FL.

ADA Code**	Plan Dentist Treatment**	Member Copayment
	Appointments	
0120	Periodic oral evaluation	No Charge
0140	Limited oral evaluation - problem focused	No Charge
0150	Comprehensive oral evaluation - new or established patient (once in any 6 calendar months)	No Charge
0180	Comprehensive periodontal evaluation - new or established patient	No Charge
None	Office visit - during regularly scheduled hours	10.00
9440	Office visit - after regularly scheduled hours	25.00
0210	X-ray - intraoral, complete series including bitewings (once in any 3 calendar years)	No Charge
0220	X-ray - intraoral, periapical first film	No Charge
0230	X-ray - intraoral, periapical each additional film	No Charge
0270	X-ray - extraoral, bitewing, single film	No Charge
0272	X-ray - bitewing, two films (once in any 6 calendar months)	No Charge
0274	X-ray - bitewing, four films (once in any 6 calendar months)	No Charge
0330	X-ray - panoramic film (once in any 3 calendar years)	No Charge
	Preventive Dentistry	
1110	Routine Prophylaxis - adult (once in any 6 calendar months)	No Charge
1120	Routine Prophylaxis - child (once in any 6 calendar months)	No Charge
1203	Topical application of fluoride (prophylaxis not included) - child	No Charge
1351	Application of sealant, per tooth	No Charge
	Restorative Dentistry (Fillings/Crowns)	
2140	Amalgam - one surface, primary or permanent	10.00
2150	Amalgam - two surfaces, primary or permanent	15.00
2160	Amalgam - three surfaces, primary or permanent	20.00
2161	Amalgam - four or more surfaces, primary or permanent	25.00
2330	Resin Filling - one surface, anterior	25.00
2331	Resin Filling - two surfaces, anterior	35.00
2332	Resin Filling - three surfaces, anterior	50.00
2335	Resin Filling - four or more surfaces or involving incisal angle, anterior	75.00
2391	Resin Filling - one surface, posterior	60.00
2392	Resin Filling - two surfaces, posterior	70.00
2393	Resin Filling - three surfaces, posterior	80.00
2394	Resin Filling - four or more surfaces, . posterior	95.00
2750*	Crown - Porcelain to high noble metal	225.00
2751*	Crown - Porcelain to base metal	225.00
2790*	Crown - full cast high noble metal	225.00
2791*	Crown - full cast base metal	225.00
2920	Recement crown	15.00

PREPAID PLAN 225 with Ortho Copayments Plan
Partial Copayment Schedule

ADA Code**	Plan Dentist Treatment**	Member Copayment
	Restorative Dentistry (Fillings/Crowns)	
2930	Prefabricated stainless steel crown - primary tooth	85.00
2950	Core buildup, including any pins	75.00
2954	Prefabricated post and core, in addition to crown	80.00
	Endodontics (Root Canals)	
3310	Root Canal - Anterior (excluding final restoration)	110.00
3320	Root Canal - Biscuspid (excluding final restoration)(S)	225.00
3330	Root Canal - Molar (excluding final restoration)(S)	250.00
	Periodontics	
4341	Periodontal scaling and root planing, four or more teeth per quadrant(S)	75.00
4910	Periodontal maintenance	45.00
	Removable Prosthodontics (Dentures)	
5110*	Complete upper denture	305.00
5120*	Complete lower denture	305.00
5213*	Partial denture - upper (cast metal framework acrylic base)	385.00
5214*	Partial denture - lower - (cast metal framework/acrylic base)	385.00
	Fixed Prosthodontics	
6751*	Crown - Porcelain fused to base metal per unit	225.00
	Oral Surgery	
7140	Extraction, erupted tooth or exposed root	18.00
7210	Surgical removal of erupted tooth removal/sectioning(S)	65.00
7230	Removal of impacted tooth - partial bony(S)	95.00
7240	Removal of impacted tooth - complete bony(S)	140.00
	Anesthesia, Analgesia, and Sedation	
9220	Deep sedation/general anesthesia (first 30 minutes)	140.00

2. Orthodontia Services

The dental services listed in the following schedule are covered when provided by a Plan Specialty Dentist. Member is responsible for paying the amount in the Member Copayment column either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

ADA Code**	Plan Dentist Treatment**	Member Copayment
	Orthodontics	
None	Bracketing (for D8070, D8080 or D8090)***	300.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	2000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	2000.00
D8090	Comprehensive orthodontic treatment of the adult dentition	2200.00
D8660	Pre-orthodontic treatment visit	100.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	250.00
D8692	Replacement of lost or broken retainer (first incident)	10.00
D8692	Replacement of lost or broken retainer (additional incidents)	50.00

3. Dental Implant Services

A $285 reduction in the charges to the Member applies for the placement of an endosteal implant (ADA Code D6010) in conjunction with one of the following crowns ADA Code D6065, D6066, or D6067. This reduction in charges applies only when the implant is used instead of replacing a single missing tooth meeting the criteria of being replaced with a traditional 3 unit, cast bridge with single pontic. The space that was occupied by the single missing tooth must currently have a tooth mesial and distal to it. The tooth loss must have occurred within the 24 month period prior to the initiation of treatment. This reduction in charges is limited to the replacement of one tooth per each arch during the lifetime of the Member. Member is responsible for paying the entire charge less the $285 reduction either at the time the service is received or in accordance with the Plan Dentist's or Plan Specialty Dentist's billing procedures. The treatment must be provided by a Plan Dentist or a Plan Specialty Dentist.

The Orthodontic Copayments listed above only apply during the first 24 months of active treatment and are only available once per lifetime. After 24 months of active treatment, the above Orthodontic Copayments are no longer applicable, and the listed services will be provided to Member at a 25% reduction from the Plan Specialty Dentist's normal retail charge. Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

This is a partial copayment schedule only. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement, Evidence of Coverage, and Copayment Schedule, which determine all rights, benefits, and applicable limitations and exclusions.

Listed copayments apply only to Plan Specialty Dentist who perform the corresponding listed services. Plan Specialty Dentist may not perform or offer all services listed. Availability and participation of Specialty Dentist are subject to change.

***Service does not have an American Dental Association Current Dental Terminology code or descriptor.

Pre-existing Conditions

Limitations and exclusions apply with respect to the Member's oral conditions without regard to whether or not such conditions existed before the effective date of the Member's enrollment.

Plan Benefits are not available for:

1. Any services not specifically described in the Copayment Schedule (including but not limited to any hospital or outpatient care facility cost associated with any dental service).

2. Any part of any dental service for which a charge is incurred before the effective date of the Member's enrollment.

3. Any dental service initiated (a) before the effective date of the Member's enrollment for Plan Benefits except as provided in the ORTHODONTIC TREATMENT Article of the Evidence of Coverage or (b) after the Member's enrollment for Plan Benefits ends.

4. Services provided by Non-Plan Providers unless for Emergency Services as specifically provided in the EMERGENCY PROCEDURES Article of the Evidence of Coverage.

5. Replacement of bridgework, dentures or other fixed or removable appliances unless (a) at least five years have elapsed since such appliance was provided as a Plan Benefit, or (b) during that five-year period, appliance becomes unusable and cannot be made usable due to the Member's illness or an accident involving damage to the appliance while it is in use.

6. Replacement of dentures or other removable appliances due to (a) damage while not in use or (b) loss or theft.

7. Oral reconstruction using fixed bridgework or other fixed appliances if the overall treatment plan to achieve complete oral reconstruction involves the replacement of six or more teeth (whether those teeth are missing before treatment begins or are extracted as part of the overall treatment plan).

8. Implants or any related implant appliances, or surgery for the insertion of implants or any related implant appliances, whether fixed or removable (except as specifically provided in the dental Implant Services section of the Copayment Schedule).

9. Replacement of any tooth that has previously been replaced by an implant.

10. Replacement of a tooth by an endosteal implant after a 24 month period has elapsed since the loss of the tooth.

11. Surgical removal of implants or implant appliances, or any surgical or non-surgical services to adjust, repair, replace, or treat any problem related to an existing implant or implant appliance, whether fixed or removable.

12. Restorations or splints used to increase vertical dimension, restore occlusion, or replace or stabilize tooth structure lost by attrition.

13. Orthodontic treatment involving therapy for myofunctional problems, TMJ (temporomandibular joint) dysfunctions, micrognathia, macroglossia, cleft palate or other growth and developmental abnormalities.

14. Orthodontic treatment associated with orthognathic surgery, whether the treatment precedes or follows the surgery.

15. Extractions of third molars (wisdom teeth) that are not symptomatic, whether or not the extractions follow the completion of orthodontic treatment. Examples of symptomatic conditions include decay, odontogenic cysts, chronic pericoronitis and infection.

16. Treatment of malignancies, neoplasms or cysts, including but not limited to biopsies.

Limitations and Exclusions

Orthodontic Extractions
Extractions by a Plan Provider for solely orthodontic purposes are not subject to the fixed Copayments shown for extractions in the Copayment Schedule. Instead, such extractions are subject to charges reflecting a 25% reduction from that Plan Provider's normal retail charges for such extractions.

Termination
The Member's enrollment may be terminated as stated in the TERMINATION article of the Evidence of Coverage.

Vision Discount Program

(Included with both the PPO and Prepaid Plan)

Access Plan

Your dental plan includes a vision discount plan through Vision Service Plan (VSP). The vision plan includes discounts on exams and the purchase of eyeglasses, contact lenses, sunglasses and other prescription eyewear when provided by VSP doctors. VSP is available for you and everyone covered on your dental plan!

Services Available from a VSP Doctor

- **Eye Exams –** 20% discount applied to VSP doctor's usual and customary fees for eye exams[1]
- **Glasses –** 20% discount applied to VSP doctor's usual and customary fees for complete pairs of prescription glasses and spectacle lens options[2]
- **Contact Lenses –** 15% discount on doctor's professional services when purchasing all prescription contact lenses[2] (materials at doctor's usual and customary fees)[3]
- **Laser VisionCare℠ –** VSP has contracted with many of the nation's laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers

VSP® Vision Care

Other Valuable Features for You

- Immediate savings when using a VSP doctor
- You may use the discounts as often as you wish
- No waiting periods
- No deductibles
- No claim forms to fill out

How to Use VSP

Locate a VSP doctor near you. You may either use our Web-based doctor locator at www.vsp.com, or call VSP at 1.800.877.7195 to request a doctor listing.

Identify yourself as a VSP member and be prepared to provide the enrolled member's social security number when you make your appointment. (The VSP doctor will verify your eligibility and vision plan coverage, and will obtain authorization for services and materials. If you are not currently eligible for services, the VSP doctor is responsible for communicating this to you.)

Your fees are automatically reduced at the time of service – with no claim forms to fill out!

VSP Member Service 800.877.7195

THIS VISION DISCOUNT PLAN IS NOT INSURANCE.
[1]Note: Does not apply to contact lens services. See contact lens section for applicable discount.
[2]Discounts only offered through the VSP doctor who provided an eye exam within the last 12 months.
[3]VSP offers valuable savings on annual supplies of selected brands of contact lenses.

How to Enroll for your 2013 dental plan

Enrolling in an Assurant Employee Benefits dental plan is easy!

Complete the state enrollment process by either:

- Enrolling online at https://peoplefirst.myflorida.com, or
- Calling People First Service Center toll free at 866.663.4735

If you need more information, please call us

Servicing Agent
State Securities Corporation
Toll free: 800.277.2300; Tallahasee: 850.386.2300

Assurant Employee Benefits
800.443.2995 (Prepaid Plan – Prepaid 225 Plan)
800.442.7742 (PPO Insured Plan – Freedom Advance)

*** IMPORTANT INFORMATION IF YOU ARE ENROLLING IN THE PREPAID PLAN (225 Plan) ***

After you have completed and submitted your state enrollment with People First Service Center, please be sure to select a General Dentist for yourself and every eligible member of your family. You can locate a list of participating General Dentists online at www.assurantemployeebenefits.com/STofFL or use our mobile app Benefit Tools.
OR you can call Assurant Employee Benefits at 800.443.2995.
Once you have selected your General Dentist, be sure to notify Assurant Employee Benefits of your dentist selection:

1) Call us at 800.443.2995; or
2) Register online at www.assurantemployeebenefits.com

September 2012

EXCITING NEWS ABOUT YOUR CURRENT DENTAL PLAN!

You are receiving this letter because you are currently enrolled in the Heritage Plus Prepaid Dental Plan with Assurant Employee Benefits. We have some great news for you! Effective January 1, 2013, the Heritage Plus plan will change to the Prepaid 225 Plan with Orthodontic Copays (the "225 Plan").

Just like the Heritage Plus Prepaid Dental plan in which you are currently enrolled, the 225 Plan does not have deductibles, annual maximums or waiting periods, and offers benefits through a network of Plan Dentists. Some of the key features and benefits offered by the 225 Plan are:

- $0 copayments for Preventive services (exams, cleanings, and x-rays);
- More than 100 additional procedures offered on the copayment listing (compared to the Heritage Plus plan);
- Lower copayments for most procedures (when compared to the Heritage Plus plan);
- 30 common specialty procedures that can be provided by your selected Plan Dentist or Plan Specialist for the same copayment. The benefit for these common specialty care procedures can provide you with greater flexibility when you are seeking dental care;
- An implant benefit; and
- Set copayments for child and adult orthodontic treatments.

You should review the differences in the plans. Please see the back of this notice for a comparison of the copayments for some of the most common services. In most cases, the copayments you will pay for dental services will be lower, but not always. You should also review the dental plan documents and the complete list of the 225 Plan copayments available on the web site at www.assurantemployeebenefits.com/STofFL. Additional information about the 225 plan will also be available at the Benefit Fairs scheduled between October 8 through November 2, 2012 for the 2013 Plan Year throughout the state, or you can request a copy of the booklet from People First at 866.663.4735.

Your bi-weekly or monthly deduction for the dental plan will change. The back of this notice also includes the bi-weekly and monthly deduction amounts.

Since you are currently enrolled in the Heritage Plus Prepaid Plan, the State will automatically enroll you in the 225 Plan. <u>You must complete the State's enrollment process through People First during this upcoming Open Enrollment period if you do not want the State to enroll you in the 225 Plan effective January 1, 2013</u>. Assurant Employee Benefits cannot make any changes to your dental plan elections.

If you have questions about the 225 Plan, call Assurant Employee Benefits at 800.443.2995. If you have questions about enrollment in the plan, contact People First at 866.663.4735. Visit the mybenefits web site and use the cost estimator to see how much you can expect to pay for your dental care in the coming year. Go to www.myflorida.com/mybenefits to obtain an estimate of your dental costs.

We encourage you to take full advantage of your upcoming once-a-year opportunity to review your benefit plan options. We truly appreciate the opportunity to provide for your dental benefits and look forward to continuing to be your dental benefit provider for years to come.

Assurant Employee Benefits is the brand name for prepaid products provided by Union Security Insurance Company. Plans contain limitations, exclusions and restrictions. For costs and additional information please contact us at 800.443.2995. Please review the 2013 Prepaid 225 Plan with Orthodontic Copays documents for complete benefit details and important benefit descriptions.

COMPARISON OF HERITAGE PLUS PREPAID PLAN and the NEW PREPAID 225 PLAN with ORTHODONTIC COPAYS for SELECTED COPAYMENTS

ADA CODE	DESCRIPTION	PLAN COPAYMENTS	
		HERITAGE PLUS Participating General Dentist Copayment (Through 12/31/12)	(new for 2013) PREPAID 225 PLAN Participating General Dentist Copayment (Effective 1/1/2013)
0120	Periodic Oral Evaluation[1]	No Charge	No Charge
0140	Limited Oral Evaluation – problem focused	$20.00	No Charge
0150	Comprehensive Oral Evaluation[1]	No Charge	No Charge
0230	Intraoral – periapical each additional film	No Charge	No Charge
0272	Bitewings – two films[1]	No Charge	No Charge
0330	Panoramic film[1]	No Charge	No Charge
1110	Routine prophylaxis – adult[1]	No Charge	No Charge
1120	Routine prophylaxis – child[1]	No Charge	No Charge
1203	Topical application of fluoride – child	No Charge	No Charge
1351	Sealant – per tooth	$10	No Charge
2140	Amalgam – one surface	$10.00	$10.00
2150	Amalgam – two surface	$15.00	$15.00
2330	Resin filling – one surface anterior	$35.00	$25.00
2331	Resin filling – two surface anterior	$45.00	$35.00
2391	Resin filling – one surface posterior	$60.00	$60.00
2392	Resin filling – two surface posterior	$70.00	$70.00
2740	Crown – porcelain to ceramic[2]	$265.00	$225.00
2750	Crown – porcelain to high noble metal[2]	$265.00	$225.00
2950	Core buildup, including any pins	$75.00	$75.00
3320	Root canal – bicuspid[3]	15% discount off Plan Specialists normal fees	$225.00
3330	Root canal – molar[3]	15% discount off Plan Specialists normal fees	$250.00
4341	Periodontal Scaling and Root Planing – four or more teeth per quadrant[3]	25% discount off Plan Specialists normal fees	$75.00
4910	Periodontal maintenance[1]	$45.00	$45.00
7140	Extraction – erupted tooth or exposed root	$15.00	$18.00
7210	Surgical removal of erupted tooth[3]	25% discount off Plan Specialists normal fees	$65.00
8080	Orthodontia treatment – child (under 19 years)	25% discount off Plan Specialists normal fees	$2,000.00
8090	Orthodontia treatment – adult (19 years or older)	25% discount off Plan Specialists normal fees	$2,200.00
[1]Please review dental plan documents for frequency limitations.			
[2]Members are responsible for additional lab fees for these services.			
[3]Note: These procedures are typically performed by a Specialist. Therefore, the member copayment or discount for these services when performed by a Plan Specialist is shown here.			

PREPAID 225 Plan with Ortho Copays	Bi-Weekly (24) Deduction	Monthly Deduction
Employee only	$7.47	$14.93
Employee + Spouse	$12.59	$25.17
Employee + Child or Children	$16.63	$33.26
Employee + Family	$21.77	$43.54

This Dental Comparison Chart provides a brief summary. Please review the detailed dental enrollment materials and dental plan documents for all plan features, including all limitations, exclusions, and restrictions.

CIGNA Dental Care Patient Charge Schedule Comparison					
K1-V8 vs. K1-V9					
Code	**Procedure Description**	**K1-V8**	**Code**	**Procedure Description**	**K1-V9**
OFFICE VISIT FEE (Per Patient, Per Office Visit in Addition to Any Other Applicable Patient Charges)			**Office visit fee (Per patient, per office visit in addition to any other applicable patient charges)**		
	Office Visit Fee	$5.00		Office visit fee	$5.00
DIAGNOSTIC/PREVENTIVE - Oral Evaluations are Limited to a Combined Total of 4 of the Following Evaluations During a 12 Consecutive Month Period: Periodic Oral Evaluations (D0120), Comprehensive Oral Evaluations, (D0150), Comprehensive Periodontal Evaluations, (D0180), and Oral Evaluations for Patients Under Three Years of Age, (D0145).			**Diagnostic/preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145).**		
D9310	Consultation (Diagnostic Service Provided By Dentist or Physician Other Than Requesting Dentist or Physician)	$0.00	D9310	Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0.00
D9430	Office Visit for Observation - No Other Services Performed	$0.00	D9430	Office visit for observation – No other services performed	$0.00
D9450	Case Presentation, Detailed and Extensive Treatment Planning	$0.00	D9450	Case presentation – Detailed and extensive treatment planning	$0.00
D0120	Periodic Oral Evaluation - Established Patient	$0.00	D0120	Periodic oral evaluation – Established patient	$0.00
D0140	Limited Oral Evaluation - Problem Focused	$0.00	D0140	Limited oral evaluation – Problem focused	$0.00
D0145	Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver	$0.00	D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive Oral Evaluation - New or Established Patient	$0.00	D0150	Comprehensive oral evaluation – New or established patient	$0.00
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, By Report	Not Covered	D0160	Detailed and extensive oral evaluation - problem focused, by report (limit 2 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)	$0.00
D0170	Re-evaluation - Limited, Problem Focused (Not Post-Operative Visit)	$0.00	D0170	Reevaluation – Limited, problem focused (not postoperative visit)	$0.00
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	$32.00	D0180	Comprehensive periodontal evaluation – New or established patient	$33.00
D0210	X-Rays Intraoral - Complete Series (Including Bitewings) (Limit 1 Every 3 Years)	$0.00	D0210	X-rays intraoral – Complete series of radiographic images (limit 1 every 3 years)	$0.00
D0220	X-Rays Intraoral Periapical, First Film	$0.00	D0220	X-rays intraoral – Periapical – First radiographic image	$0.00
D0230	X-Rays Intraoral Periapical, Each Additional Film	$0.00	D0230	X-rays intraoral – Periapical – Each additional radiographic image	$0.00
D0240	X-Rays Intraoral - Occlusal Film	$0.00	D0240	X-rays intraoral – Occlusal radiographic image	$0.00
D0250	X-Rays Extraoral – First Film	Not Covered	D0250	X-rays extraoral – First radiographic image	Not Covered
D0260	X-Rays Extraoral – Each Additional Film	Not Covered	D0260	X-rays extraoral – Each additional radiographic image	Not Covered
D0270	X-Rays (Bitewing) - Single Film	$0.00	D0270	X-rays (bitewing) – Single radiographic image	$0.00
D0272	X-Rays (Bitewings) - Two Films	$0.00	D0272	X-rays (bitewings) – 2 radiographic images	$0.00
D0273	X-Rays (Bitewings) - Three films	$0.00	D0273	X-rays (bitewings) – 3 radiographic images	$0.00
D0274	X-Rays (Bitewings) - Four Films	$0.00	D0274	X-rays (bitewings) – 4 radiographic images	$0.00
D0277	X-Rays (Bitewings, Vertical) - 7 to 8 Films	$0.00	D0277	X-rays (bitewings, vertical) – 7 to 8 radiographic images	$0.00
D0330	X-Rays (Panoramic Film) - (Limit 1 Every 3 years)	$0.00	D0330	X-rays (panoramic radiographic image) – (limit 1 every 3 years)	$0.00
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw (only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)	Not Covered	D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw (only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)	Not Covered
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible (only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)	Not Covered	D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible (only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)	Not Covered
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium (only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)	Not Covered	D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium (only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)	Not Covered

D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium (only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)	Not Covered	D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium (only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)	Not Covered
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures (limit 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)	Not Covered	D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures (limit 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)	$240.00
D0350	Oral/Facial Photographic Images	Not Covered	D0350	Oral/facial photographic images	Not Covered
D0415	Collection of Microorganisms for Culture and Sensitivity	Not Covered	D0415	Collection of microorganisms for culture and sensitivity	Not Covered
D0425	Caries Susceptibility Tests	Not Covered	D0425	Caries susceptibility tests	Not Covered
D0431	Oral Cancer Screening Using a Special Light Source	$50.00	D0431	Oral cancer screening using a special light source	$50.00
D0460	Pulp Vitality Tests	$13.00	D0460	Pulp vitality tests	$14.00
D0470	Diagnostic Casts	$0.00	D0470	Diagnostic casts	$0.00
D0472	Pathology Report - Gross Examination of Lesion (Only When Tooth Related)	$0.00	D0472	Pathology report – Gross examination of lesion (only when tooth related)	$0.00
D0473	Pathology Report - Microscopic Examination of Lesion (Only When Tooth Related)	$0.00	D0473	Pathology report – Microscopic examination of lesion (only when tooth related)	$0.00
D0474	Pathology Report - Microscopic Examination of Lesion and Area (Only When Tooth Related)	$0.00	D0474	Pathology report – Microscopic examination of lesion and area (only when tooth related)	$0.00
D0486	Accession of Brush Biopsy Sample, Microscopic Examination, Preparation and Transmission of Written Report	Not Covered	D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	Not Covered
D1110	Prophylaxis (Cleaning) - Adult (Limit 2 Per Calendar Year)	$0.00	D1110	Prophylaxis (cleaning) – Adult (limit 2 per calendar year)	$0.00
	Additional Prophylaxis (Cleaning), In Addition to the Two Prophylaxes (Cleaning) Allowed Per Calendar Year	$45.00		Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year	$45.00
D1120	Prophylaxis (Cleaning) - Child (Limit 2 Per Calendar Year)	$0.00	D1120	Prophylaxis (cleaning) – Child (limit 2 per calendar year)	$0.00
	Additional Prophylaxis (Cleaning), In Addition to the Two Prophylaxes (Cleaning) Allowed Per Calendar Year	$30.00		Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year	$30.00
D1203	Topical Application of Fluoride - Child (Up to 19th Birthday) (Limited to 2 Per Calendar Year). There is a Combined Limit of a Total of Two D1203s and/or	$0.00	D1208	Topical application of fluoride (limit 2 per calendar year) There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year.	$0.00
D1204	Topical Fluoride Application – Adult	Not Covered		Additional topical application of fluoride - In addition to any combination of two (2) D1206s (topical applications of fluoride varnish) and/or D1208s (topical application of fluoride) per calendar year	$15.00
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients. Child (Up to 19th Birthday)(Limited to 2 Per Calendar Year). There is a	$0.00	D1206	Topical application of fluoride varnish – (limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year.	$0.00
	Additional topical application of fluoride varnish in addition to any combination of two (2) D1206s (topical application of fluoride varnish) and/or D1208s (topical application of fluoride) per calendar year.	Not Covered		Additional topical application of fluoride varnish in addition to any combination of two (2) D1206s (topical application of fluoride varnish) and/or D1208s (topical application of fluoride) per calendar year.	$15.00
D1310	Nutritional Counseling for Control of Dental Disease	Not Covered	D1310	Nutritional counseling for control of dental disease	Not Covered
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease	Not Covered	D1320	Tobacco counseling for the control and prevention of oral disease	Not Covered
D1330	Oral Hygiene Instructions	$0.00	D1330	Oral hygiene instructions	$0.00
D1351	Sealant - Per Tooth	$11.00	D1351	Sealant – Per tooth	$12.00
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth	$11.00	D1352	Preventive resin restoration in a moderate to high caries risk patient – Permanent tooth	$12.00
D1510	Space Maintainer - Fixed Unilateral	$105.00	D1510	Space maintainer – Fixed – Unilateral	$110.00
D1515	Space Maintainer - Fixed Bilateral	$165.00	D1515	Space maintainer – Fixed – Bilateral	$170.00
D1520	Space Maintainer - Removable - Unilateral	Not Covered	D1520	Space maintainer – Removable – Unilateral	Not Covered
D1525	Space Maintainer - Removable - Bilateral	Not Covered	D1525	Space maintainer – Removable – Bilateral	Not Covered
D1550	Recementation of Space Maintainer	Not Covered	D1550	Recementation of space maintainer	Not Covered
D1555	Removal of Fixed Space Maintainer	$0.00	D1555	Removal of fixed space maintainer	$0.00
RESTORATIVE (Fillings)			**Restorative (fillings, including polishing)**		
D2140	Amalgam - One Surface, Primary or Permanent	$0.00	D2140	Amalgam – 1 surface, primary or permanent	$0.00

D2150	Amalgam - Two Surfaces, Primary or Permanent	$0.00	D2150	Amalgam – 2 surfaces, primary or permanent	$0.00
D2160	Amalgam - Three Surfaces, Primary or Permanent	$0.00	D2160	Amalgam – 3 surfaces, primary or permanent	$0.00
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	$0.00	D2161	Amalgam – 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-Based Composite - One Surface, Anterior	$0.00	D2330	Resin-based composite – 1 surface, anterior	$0.00
D2331	Resin-Based Composite - Two Surfaces, Anterior	$0.00	D2331	Resin-based composite – 2 surfaces, anterior	$0.00
D2332	Resin-Based Composite - Three Surfaces, Anterior	$0.00	D2332	Resin-based composite – 3 surfaces, anterior	$0.00
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	$85.00	D2335	Resin-based composite – 4 or more surfaces or involving incisal angle, anterior	$88.00
D2390	Resin-Based Composite Crown, Anterior	$85.00	D2390	Resin-based composite crown, anterior	$88.00
D2391	Resin-Based Composite - One Surface, Posterior	$45.00	D2391	Resin-based composite – 1 surface, posterior	$47.00
D2392	Resin-Based Composite - Two Surfaces, Posterior	$57.00	D2392	Resin-based composite – 2 surfaces, posterior	$59.00
D2393	Resin-Based Composite - Three Surfaces, Posterior	$79.00	D2393	Resin-based composite – 3 surfaces, posterior	$82.00
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	$110.00	D2394	Resin-based composite – 4 or more surfaces, posterior	$115.00
CROWN AND BRIDGE All charges for crown and bridge (fixed partial denture) are per unit (each replacement or supporting tooth equals one unit) - Replacement limit 1 every 5 years.			**Crown and bridge – All charges for crown and bridge (fixed partial denture) are per unit (each replacement or supporting tooth equals 1 unit).Coverage for replacement of crowns and bridges is limited to 1 every 5 years.**		
	Per tooth charge for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) Services. Same day in-office CAD/CAM (ceramic) Services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine.	Not Covered		Per tooth charge for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) Services. Same day in-office CAD/CAM (ceramic) Services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine.	$150.00
D2510	Inlay - Metallic - One Surface	$400.00	D2510	Inlay – Metallic – 1 surface	$410.00
D2520	Inlay - Metallic - Two Surfaces	$400.00	D2520	Inlay – Metallic – 2 surfaces	$410.00
D2530	Inlay - Metallic - Three or More Surfaces	$400.00	D2530	Inlay – Metallic – 3 or more surfaces	$410.00
D2542	Onlay - Metallic - Two Surfaces	$460.00	D2542	Onlay – Metallic – 2 surfaces	$470.00
D2543	Onlay - Metallic - Three Surfaces	$460.00	D2543	Onlay – Metallic – 3 surfaces	$470.00
D2544	Onlay - Metallic - Four or More Surfaces	$460.00	D2544	Onlay – Metallic – 4 or more surfaces	$470.00
D2610	Inlay – Porcelain/Ceramic – One Surface	Not Covered	D2610	Inlay – Porcelain/ceramic, 1 surface	Not Covered
D2620	Inlay – Porcelain/Ceramic – Two Surfaces	Not Covered	D2620	Inlay – Porcelain/ceramic, 2 surfaces	Not Covered
D2630	Inlay – Porcelain/Ceramic – Three or More Surfaces	Not Covered	D2630	Inlay – Porcelain/ceramic, 3 or more surfaces	Not Covered
D2642	Onlay – Porcelain/Ceramic – Two Surfaces	Not Covered	D2642	Onlay – Porcelain/ceramic, 2 surfaces	Not Covered
D2643	Onlay – Porcelain/Ceramic – Three Surfaces	Not Covered	D2643	Onlay – Porcelain/ceramic, 3 surfaces	Not Covered
D2644	Onlay – Porcelain/Ceramic – Four or More Surfaces	Not Covered	D2644	Onlay – Porcelain/ceramic, 4 or more surfaces	Not Covered
D2650	Inlay – Resin-Based Composite – One Surface	Not Covered	D2650	Inlay – Resin-based composite, 1 surface	Not Covered
D2651	Inlay – Resin-Based Composite – Two Surfaces	Not Covered	D2651	Inlay – Resin-based composite, 2 surfaces	Not Covered
D2652	Inlay – Resin-Based Composite – Three or More Surfaces	Not Covered	D2652	Inlay – Resin-based composite, 3 or more surfaces	Not Covered
D2662	Onlay – Resin-Based Composite – Two Surfaces	Not Covered	D2662	Onlay – Resin-based composite, 2 surfaces	Not Covered
D2663	Onlay – Resin-Based Composite – Three Surfaces	Not Covered	D2663	Onlay – Resin-based composite, 3 surfaces	Not Covered
D2664	Onlay – Resin-Based Composite – Four or More Surfaces	Not Covered	D2664	Onlay – Resin-based composite, 4 or more surfaces	Not Covered
D2710	Crown - Resin (Laboratory)	Not Covered	D2710	Crown – Resin, laboratory	Not Covered
D2712	Crown – 3/4 Resin-Based Composite (Indirect)	Not Covered	D2712	Crown – 3/4 resin-based composite, indirect	Not Covered
D2720	Crown - Resin with High Noble Metal	Not Covered	D2720	Crown – Resin with high noble metal	Not Covered
D2721	Crown - Resin with Predominantly Base Metal	Not Covered	D2721	Crown – Resin with predominantly base metal	Not Covered
D2722	Crown - Resin with Noble Metal	Not Covered	D2722	Crown – Resin with noble metal	Not Covered
D2740	Crown - Porcelain/Ceramic Substrate	$490.00	D2740	Crown – Porcelain/ceramic substrate	$490.00
D2750	Crown - Porcelain Fused to High Noble Metal	$450.00	D2750	Crown – Porcelain fused to high noble metal	$450.00
D2751	Crown - Porcelain Fused to Predominantly Base Metal	$400.00	D2751	Crown – Porcelain fused to predominantly base metal	$400.00
D2752	Crown - Porcelain Fused to Noble Metal	$425.00	D2752	Crown – Porcelain fused to noble metal	$425.00

D2780	Crown - 3/4 Cast High Noble Metal	$450.00	D2780	Crown – 3/4 cast high noble metal	$460.00
D2781	Crown - 3/4 Cast Predominantly Base Metal	$400.00	D2781	Crown – 3/4 cast predominantly base metal	$410.00
D2782	Crown - 3/4 Cast Noble Metal	$425.00	D2782	Crown – 3/4 cast noble metal	$435.00
D2783	Crown –3/4 Porcelain/Ceramic	Not Covered	D2783	Crown – 3/4 porcelain/ceramic	Not Covered
D2790	Crown - Full Cast High Noble Metal	$450.00	D2790	Crown – Full cast high noble metal	$460.00
D2791	Crown - Full Cast Predominantly Base Metal	$400.00	D2791	Crown – Full cast predominantly base metal	$410.00
D2792	Crown - Full Cast Noble Metal	$425.00	D2792	Crown – Full cast noble metal	$435.00
D2794	Crown - Titanium	$450.00	D2794	Crown – Titanium	$460.00
D2799	Provisional crown	Not Covered	D2799	Provisional crown	Not Covered
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	$42.00	D2910	Recement inlay – Onlay or partial coverage restoration	$43.00
D2915	Recement Cast or Prefabricated Post and Core	$42.00	D2915	Recement cast or prefabricated post and core	$43.00
D2920	Recement Crown	$42.00	D2920	Recement crown	$43.00
D2929	Prefabricated porcelain/ceramic crown - Primary tooth	Not Covered	D2929	Prefabricated porcelain/ceramic crown - Primary tooth	$165.00
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$100.00	D2930	Prefabricated stainless steel crown – Primary tooth	$105.00
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	$100.00	D2931	Prefabricated stainless steel crown – Permanent tooth	$105.00
D2932	Prefabricated Resin Crown	$130.00	D2932	Prefabricated resin crown	$135.00
D2933	Prefabricated Stainless Steel Crown with Resin Window	$160.00	D2933	Prefabricated stainless steel crown with resin window	$165.00
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	$160.00	D2934	Prefabricated esthetic coated stainless steel crown – Primary tooth	$165.00
D2940	Protective Restoration	$12.00	D2940	Protective restoration	$13.00
D2950	Core Buildup, Including Any Pins	$130.00	D2950	Core buildup – Including any pins	$135.00
D2951	Pin Retention - Per Tooth, In Addition to Restoration	$12.00	D2951	Pin retention – Per tooth – In addition to restoration	$13.00
D2952	Post and Core In Addition to Crown, Indirectly Fabricated	$160.00	D2952	Post and core – In addition to crown, indirectly fabricated	$165.00
D2953	Each Additional Cast Post - Same Tooth	Not Covered	D2953	Each additional cast post – Same tooth	Not Covered
D2954	Prefabricated Post and Core In Addition to Crown	$130.00	D2954	Prefabricated post and core – In addition to crown	$135.00
D2957	Each Additional Prefabricated Post - Same Tooth - Base Metal Post	Not Covered	D2957	Each additional prefabricated post – Same tooth – Base metal post	Not Covered
D2960	Labial veneer (Resin Laminate) - Chairside	$91.00	D2960	Labial veneer (resin laminate) – Chairside	$94.00
D2970	Temporary Crown - Fractured Tooth	Not Covered	D2970	Temporary crown – Fractured tooth	Not Covered
D2971	Additional Procedures to Construct New Crown Under Existing Partial Denture Framework	Not Covered	D2971	Additional procedures to construct new crown under existing partial denture framework	Not Covered
D2980	Crown Repair	Not Covered	D2980	Crown repair, necessitated by restorative material failure	Not Covered
D6210	Pontic - Cast High Noble Metal	$450.00	D6210	Pontic – Cast high noble metal	$450.00
D6211	Pontic - Cast Predominantly Base Metal	$400.00	D6211	Pontic – Cast predominantly base metal	$410.00
D6212	Pontic - Cast Noble Metal	$425.00	D6212	Pontic – Cast noble metal	$435.00
D6214	Pontic Titanium	$450.00	D6214	Pontic – Titanium	$460.00
D6240	Pontic - Porcelain Fused to High Noble Metal	$450.00	D6240	Pontic – Porcelain fused to high noble metal	$450.00
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	$400.00	D6241	Pontic – Porcelain fused to predominantly base metal	$410.00
D6242	Pontic - Porcelain Fused to Noble Metal	$425.00	D6242	Pontic – Porcelain fused to noble metal	$435.00
D6245	Pontic - Porcelain/Ceramic	$445.00	D6245	Pontic – Porcelain/ceramic	$455.00
D6250	Pontic - Resin with High Noble Metal	Not Covered	D6250	Pontic – Resin with high noble metal	Not Covered
D6251	Pontic - Resin with Predominantly Base Metal	Not Covered	D6251	Pontic – Resin with predominantly base metal	Not Covered
D6252	Pontic - Resin with Noble Metal	Not Covered	D6252	Pontic – Resin with noble metal	Not Covered
D6253	Provisional Pontic	Not Covered	D6253	Provisional pontic	Not Covered
D6545	Retainer – Cast Metal for Resin Bonded Fixed Prosthesis	Not Covered	D6545	Retainer – Cast metal for resin bonded fixed prosthesis	Not Covered
D6600	Inlay – Porcelain/Ceramic, Two Surfaces	Not Covered	D6600	Inlay – Porcelain/ceramic, 2 surfaces	Not Covered
D6601	Inlay – Porcelain/Ceramic, Three or More Surfaces	Not Covered	D6601	Inlay – Porcelain/ceramic, 3 or more surfaces	Not Covered
D6602	Inlay - Cast High Noble Metal, Two Surfaces	$450.00	D6602	Inlay – Cast high noble metal, 2 surfaces	$450.00
D6603	Inlay - Cast High Noble Metal, Three or More Surfaces	$450.00	D6603	Inlay – Cast high noble metal, 3 or more surfaces	$460.00

D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces	$390.00	D6604	Inlay – Cast predominantly base metal, 2 surfaces	$390.00
D6605	Inlay - Cast Predominantly Base Metal, Three or More Surfaces	$390.00	D6605	Inlay – Cast predominantly base metal, 3 or more surfaces	$400.00
D6606	Inlay - Cast Noble Metal, Two Surfaces	$415.00	D6606	Inlay – Cast noble metal, 2 surfaces	$415.00
D6607	Inlay - Cast Noble Metal, Three or More Surfaces	$425.00	D6607	Inlay – Cast noble metal, 3 or more surfaces	$425.00
D6608	Onlay – Porcelain/Ceramic, Two Surfaces	Not Covered	D6608	Onlay – Porcelain/ceramic, 2 surfaces	Not Covered
D6609	Onlay – Porcelain/Ceramic, Three or More Surfaces	Not Covered	D6609	Onlay – Porcelain/ceramic, 3 or more surfaces	Not Covered
D6610	Onlay - Cast High Noble Metal, Two Surfaces	$440.00	D6610	Onlay – Cast high noble metal, 2 surfaces	$440.00
D6611	Onlay - Cast High Noble Metal, Three or More Surfaces	$450.00	D6611	Onlay – Cast high noble metal, 3 or more surfaces	$460.00
D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces	$390.00	D6612	Onlay – Cast predominantly base metal, 2 surfaces	$390.00
D6613	Onlay - Cast Predominantly Base Metal, Three or More Surfaces	$390.00	D6613	Onlay – Cast predominantly base metal, 3 or more surfaces	$400.00
D6614	Onlay - Cast Noble Metal, Two Surfaces	$415.00	D6614	Onlay – Cast noble metal, 2 surfaces	$415.00
D6615	Onlay - Cast Noble Metal, Three or More Surfaces	$425.00	D6615	Onlay – Cast noble metal, 3 or more surfaces	$435.00
D6624	Inlay Titanium	$450.00	D6624	Inlay – Titanium	$450.00
D6634	Onlay Titanium	$450.00	D6634	Onlay – Titanium	$450.00
D6710	Crown – Indirect Resin Based Composite	Not Covered	D6710	Crown – Indirect resin based composite	Not Covered
D6720	Crown - Resin with High Noble Metal	Not Covered	D6720	Crown – Resin with high noble metal	Not Covered
D6721	Crown - Resin with Predominantly Base Metal	Not Covered	D6721	Crown – Resin with predominantly base metal	Not Covered
D6722	Crown - Resin with Noble Metal	Not Covered	D6722	Crown – Resin with noble metal	Not Covered
D6740	Crown - Porcelain/Ceramic	$490.00	D6740	Crown – Porcelain/ceramic	$500.00
D6750	Crown - Porcelain Fused to High Noble Metal	$450.00	D6750	Crown – Porcelain fused to high noble metal	$460.00
D6751	Crown - Porcelain Fused to Predominantly Base Metal	$400.00	D6751	Crown – Porcelain fused to predominantly base metal	$410.00
D6752	Crown - Porcelain Fused to Noble Metal	$425.00	D6752	Crown – Porcelain fused to noble metal	$435.00
D6780	Crown - 3/4 Cast High Noble Metal	$450.00	D6780	Crown – 3/4 cast high noble metal	$460.00
D6781	Crown - 3/4 Cast Predominantly Base Metal	$400.00	D6781	Crown – 3/4 cast predominantly base metal	$410.00
D6782	Crown - 3/4 Cast Noble Metal	$425.00	D6782	Crown – 3/4 cast noble metal	$435.00
D6783	Crown – 3/4 Porcelain/Ceramic	Not Covered	D6783	Crown – 3/4 porcelain/ceramic	Not Covered
D6790	Crown - Full Cast High Noble Metal	$450.00	D6790	Crown – Full cast high noble metal	$460.00
D6791	Crown - Full Cast Predominantly Base Metal	$400.00	D6791	Crown – Full cast predominantly base metal	$410.00
D6792	Crown - Full Cast Noble Metal	$425.00	D6792	Crown – Full cast noble metal	$435.00
D6794	Crown Titanium	$450.00	D6794	Crown – Titanium	$460.00
	Complex Rehabilitation - ADDITIONAL CHARGE PER UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION (6 OR MORE UNITS OF CROWN AND/OR BRIDGE IN SAME TREATMENT PLAN REQUIRES COMPLEX REHABILITATION FOR EACH UNIT - ASK YOUR DENTIST FOR THE GUIDELINES)	$135.00		Complex rehabilitation – Additional charge per unit for multiple crown units/complex rehabilitation (6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)	$135.00
D6930	Recement Fixed Partial Denture	$59.00	D6930	Recement fixed partial denture	$61.00
D6940	Stress Breaker	Not Covered	D6940	Stress breaker	Not Covered
D6950	Precision Attachment	Not Covered	D6950	Precision attachment	Not Covered
D6970	Cast Post and Core, In Addition to Fixed Partial Denture Retainer	Not Covered	D6970	Cast Post and Core, In Addition to Fixed Partial Denture Retainer	Not Covered
D6972	Prefabricated Post and Core In Addition to Fixed Partial Denture Retainer - Base Metal Post	Not Covered	D6972	Prefabricated Post and Core In Addition to Fixed Partial Denture Retainer - Base Metal Post	Not Covered
D6973	Core Buildup For Retainer, Including Any Pins	Not Covered	D6973	Core Buildup For Retainer, Including Any Pins	Not Covered
D6976	Each Additional Cast Post - Same Tooth	Not Covered	D6976	Each Additional Cast Post - Same Tooth	Not Covered
D6977	Each Additional Prefabricated Post - Same Tooth	Not Covered	D6977	Each Additional Prefabricated Post - Same Tooth	Not Covered
D6980	Fixed Partial Denture Repair	Not Covered	D6980	Fixed Partial Denture Repair	Not Covered

IMPLANT SUPPORTED PROSTHETICS - All charges for crown and bridge (fixed partial denture) are per unit (each replacement on a supporting implant(s) equals one unit) - Replacement limit 1 every 5 years. All charges for an implant supported denture are limited to replacement of 1 every 5 years.		
	Per tooth charge for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) Services. Same day in-office CAD/CAM (ceramic) Services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine.	Not Covered
D6053	Implant/Abutment Supported Removable Denture for Completely Edentulous Arch	$925.00
D6054	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch	$1,015.00
D6058	Abutment Supported Porcelain/Ceramic Crown	$790.00
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	$750.00
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)	$700.00
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)	$725.00
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	$750.00
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	$700.00
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	$725.00
D6065	Implant Supported Porcelain/Ceramic Crown	$790.00
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$750.00
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$750.00
D6068	Abutment Supported Retainer for Porcelain/Ceramic Fixed Partial Denture	$790.00
D6069	Abutment Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (High Noble Metal)	$750.00
D6070	Abutment Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (Predominantly Base Metal)	$700.00
D6071	Abutment Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (Noble Metal)	$725.00
D6072	Abutment Supported Retainer for Cast Metal Fixed Partial Denture (High Noble Metal)	$750.00
D6073	Abutment Supported Retainer for Cast Metal Fixed Partial Denture (Predominantly Base Metal)	$700.00
D6074	Abutment Supported Retainer for Cast Metal Fixed Partial Denture (Noble Metal)	$725.00
D6075	Implant Supported Retainer for Ceramic Fixed Partial Denture	$790.00
D6076	Implant Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (Titanium, Titanium Alloy, High Noble Metal)	$750.00
D6077	Implant Supported Retainer for Cast Metal Fixed Partial Denture (Titanium, Titanium Alloy, High Noble Metal)	$750.00
D6078	Implant/ Abutment Supported Fixed Denture for Completely Edentulous Arch	$925.00
D6079	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch	$1,015.00
D6092	Recement Implant/Abutment Supported Crown	$82.00
D6093	Recement Implant/Abutment Supported Fixed Partial Denture	$99.00
D6094	Abutment Supported Crown (Titanium)	$750.00
D6194	Abutment Supported Retainer Crown for Fixed Partial Denture (Titanium)	$750.00

Implant/abutment supported prosthetics – All charges for crown and bridge (fixed partial denture) are per unit (each replacement on a supporting implant(s) equals 1 unit). Coverage for replacement of crowns and bridges and implant supported dentures is limited to 1 every 5 years.		
	Per tooth charge for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) Services. Same day in-office CAD/CAM (ceramic) Services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine.	$150.00
D6053	Implant/abutment supported removable denture for completely edentulous arch	$925.00
D6054	Implant/abutment supported removable denture for partially edentulous arch	$1,015.00
D6058	Abutment supported porcelain/ceramic crown	$790.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$750.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$700.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$725.00
D6062	Abutment supported cast metal crown (high noble metal)	$750.00
D6063	Abutment supported cast metal crown (predominantly base metal)	$700.00
D6064	Abutment supported cast metal crown (noble metal)	$725.00
D6065	Implant supported porcelain/ceramic crown	$790.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$750.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$750.00
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	$790.00
D6069	Abutment supported retainer for porcelain fused to metal fixed partial denture (high noble metal)	$750.00
D6070	Abutment supported retainer for porcelain fused to metal fixed partial denture (predominantly base metal)	$700.00
D6071	Abutment supported retainer for porcelain fused to metal fixed partial denture (noble metal)	$725.00
D6072	Abutment supported retainer for cast metal fixed partial denture (high noble metal)	$750.00
D6073	Abutment supported retainer for cast metal fixed partial denture (predominantly base metal)	$700.00
D6074	Abutment supported retainer for cast metal fixed partial denture (noble metal)	$725.00
D6075	Implant supported retainer for ceramic fixed partial denture	$790.00
D6076	Implant supported retainer for porcelain fused to metal fixed partial denture (titanium, titanium alloy, high noble metal)	$750.00
D6077	Implant supported retainer for cast metal fixed partial denture (titanium, titanium alloy, high noble metal)	$750.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch	$925.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch	$1,015.00
D6092	Recement implant/abutment supported crown	$82.00
D6093	Recement implant/abutment supported fixed partial denture	$99.00
D6094	Abutment supported crown (titanium)	$750.00
D6194	Abutment supported retainer crown for fixed partial denture (titanium)	$750.00

	Complex Rehabilitation on Implant Supported Prosthetic Procedures - ADDITIONAL CHARGE PER UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION (6 OR MORE UNITS OF CROWN AND/OR BRIDGE IN SAME TREATMENT PLAN REQUIRES COMPLEX REHABILITATION FOR EACH UNIT - ASK YOUR DENTIST FOR THE GUIDELINES)	$135.00		Complex rehabilitation on implant/abutment supported prosthetic procedures – Additional charge per unit for multiple crown units/complex rehabilitation (6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)	$135.00
ENDODONTICS (Root Canal Treatment, Excluding Final Restorations)			**Endodontics (root canal treatment, excluding final restorations)**		
D3110	Pulp Cap - Direct (Excluding Final Restoration)	$13.00	D3110	Pulp cap – Direct (excluding final restoration)	$14.00
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	$13.00	D3120	Pulp cap – Indirect (excluding final restoration)	$14.00
D3220	Pulpotomy - Removal of Pulp, Not Part of a Root Canal	$68.00	D3220	Pulpotomy – Removal of pulp, not part of a root canal	$72.00
D3221	Pulpal Debridement (Not to be used when root canal is done on the same day)	$68.00	D3221	Pulpal debridement (not to be used when root canal is done on the same day)	$72.00
D3222	Partial Pulpotomy for Apexogenesis-Permanent Tooth with Incomplete Root Development	$68.00	D3222	Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development	$72.00
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)	Not Covered	D3230	Pulpal therapy (resorbable filling) – Anterior, primary tooth (excluding final restoration)	Not Covered
D3240	Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restoration)	Not Covered	D3240	Pulpal therapy (resorbable filling) – Posterior, primary tooth (excluding final restoration)	Not Covered
D3310	Anterior Root Canal (Permanent Tooth) (Excluding Final Restoration)	$210.00	D3310	Anterior root canal – Permanent tooth (excluding final restoration)	$210.00
D3320	Bicuspid Root Canal (Permanent Tooth) (Excluding Final Restoration)	$245.00	D3320	Bicuspid root canal – Permanent tooth (excluding final restoration)	$245.00
D3330	Molar Root Canal (Permanent Tooth) (Excluding Final Restoration)	$335.00	D3330	Molar root canal – Permanent tooth (excluding final restoration)	$335.00
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access	$92.00	D3331	Treatment of root canal obstruction – Nonsurgical access	$97.00
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth	$92.00	D3332	Incomplete endodontic therapy – Inoperable, unrestorable or fractured tooth	$97.00
D3333	Internal Root Repair of Perforation Defects	$92.00	D3333	Internal root repair of perforation defects	$97.00
D3346	Retreatment of Previous Root Canal Therapy - Anterior	$285.00	D3346	Retreatment of previous root canal therapy – Anterior	$300.00
D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	$325.00	D3347	Retreatment of previous root canal therapy – Bicuspid	$345.00
D3348	Retreatment of Previous Root Canal Therapy - Molar	$410.00	D3348	Retreatment of previous root canal therapy – Molar	$430.00
D3351	Apexification/Recalcification – Initial Visit (Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)	Not Covered	D3351	Apexification/recalcification – Initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	Not Covered
D3352	Apexification/Recalcification – Interim Medication Replacement (Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)	Not Covered	D3352	Apexification/recalcification – Interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	Not Covered
D3353	Apexification/Recalcification – Final Visit (Includes Completed Root Canal Therapy – Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)	Not Covered	D3353	Apexification/recalcification – Final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	Not Covered
D3410	Apicoectomy/Periradicular Surgery Anterior	$260.00	D3410	Apicoectomy/periradicular surgery – Anterior	$275.00
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	$290.00	D3421	Apicoectomy/periradicular surgery – Bicuspid (first root)	$305.00
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	$320.00	D3425	Apicoectomy/periradicular surgery – Molar (first root)	$340.00
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	$105.00	D3426	Apicoectomy/periradicular surgery (each additional root)	$110.00
D3430	Retrograde Filling - Per Root	$68.00	D3430	Retrograde filling per root	$72.00
D3450	Root Amputation – Per Root	Not Covered	D3450	Root amputation per root (not covered in conjunction with procedure d3920)	Not Covered
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	Not Covered	D3920	Hemisection (including any root removal), not including root canal therapy	Not Covered
PERIODONTICS (Treatment of Supporting Tissues Gum and Bone of the Teeth) Periodontal Regenerative Procedures are Limited to One Regenerative Procedure Per Site (or Per Tooth, if Applicable), When Covered on the Patient Charge Schedule. The Relevant Procedure Codes are D4263, D4264, D4266 and D4267. Localized Delivery of Antimicrobial Agents is Limited to Eight Teeth (or Eight Sites, if Applicable) Per 12 Consecutive Months, When Covered on the Patient Charge Schedule			**Periodontics (treatment of supporting tissues [gum and bone] of the teeth) periodontal regenerative procedures are limited to 1 regenerative procedure per site (or per tooth, if applicable), when covered on the patient charge schedule. The relevant procedure codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 teeth (or 8 sites, if applicable) per 12 consecutive months when covered on the patient charge schedule.**		

D4210	Gingivectomy or Gingivoplasty - 4 or More Teeth, Per Quadrant	$170.00	D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	$180.00
D4211	Gingivectomy or Gingivoplasty - 1 to 3 Teeth, Per Quadrant	$86.00	D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant	$91.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Not Covered	D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$91.00
D4240	Gingival Flap, Including Root Planing - 4 or More Teeth, Per Quadrant	$220.00	D4240	Gingival flap (including root planing) – 4 or more teeth per quadrant	$235.00
D4241	Gingival Flap, Including Root Planing - 1 to 3 Teeth, Per Quadrant	$115.00	D4241	Gingival flap (including root planing) – 1 to 3 teeth per quadrant	$125.00
D4245	Apically Positioned Flap	$220.00	D4245	Apically positioned flap	$235.00
D4249	Clinical Crown Lengthening - Hard Tissue	$240.00	D4249	Clinical crown lengthening – Hard tissue	$255.00
D4260	Osseous Surgery - 4 or More Teeth, Per Quadrant	$400.00	D4260	Osseous surgery – 4 or more teeth per quadrant	$400.00
D4261	Osseous Surgery - 1 to 3 Teeth, Per Quadrant	$225.00	D4261	Osseous surgery – 1 to 3 teeth per quadrant	$240.00
D4263	Bone Replacement Graft - First Site in Quadrant	$290.00	D4263	Bone replacement graft – First site in quadrant	$290.00
D4264	Bone Replacement Graft - Each Additional Site in Quadrant	$225.00	D4264	Bone replacement graft – Each additional site in quadrant	$225.00
D4265	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration	Not Covered	D4265	Biologic materials to aid in soft and osseous tissue regeneration	Not Covered
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	$380.00	D4266	Guided tissue regeneration – Resorbable barrier per site	$380.00
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	$430.00	D4267	Guided tissue regeneration – Nonresorbable barrier per site (includes membrane removal)	$430.00
D4270	Pedicle Soft Tissue Graft Procedure	$285.00	D4270	Pedicle soft tissue graft procedure	$300.00
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	$295.00	D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous (missing) tooth position in graft	$310.00
D4273	Subepithelial Connective Tissue Graft Procedures, Per Tooth	Not Covered	D4273	Subepithelial connective tissue graft procedures, per tooth	Not Covered
D4274	Distal or Proximal Wedge Procedure (When Not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area)	Not Covered	D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	Not Covered
D4275	Soft Tissue Allograft	$295.00	D4275	Soft tissue allograft	$310.00
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous (missing) tooth position in same graft site	Not Covered	D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous (missing) tooth position in same graft site	$155.00
D4341	Periodontal Scaling and Root Planing - 4 or More Teeth Per Quadrant (Limit 4 Quadrants per Consecutive 12 Months)	$83.00	D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant (limit 4 quadrants per consecutive 12 months)	$83.00
D4342	Periodontal Scaling and Root Planing - 1 to 3 Teeth, Per Quadrant (Limit 4 Quadrants per Consecutive 12 Months)	$42.00	D4342	Periodontal scaling and root planing – 1 to 3 teeth – per quadrant (limit 4 quadrants per consecutive 12 months)	$42.00
D4355	Full Mouth Debridement to Allow Evaluation and Diagnosis (1 Per Lifetime)	$62.00	D4355	Full mouth debridement to allow evaluation and diagnosis (1 per lifetime)	$65.00
D4381	Localized Delivery of Antimicrobial Agents, Per Tooth, By Report	$45.00	D4381	Localized delivery of antimicrobial agents per tooth	$45.00
D4910	Periodontal Maintenance (Limited to 2 Per Calendar Year) Only Covered After Active Therapy.	$50.00	D4910	Periodontal maintenance (limit 4 per calendar year) (only covered after active periodontal therapy)	$53.00
	Additional Periodontal Maintenance Procedures (Beyond 2 Per Calendar Year)	Not Covered		Additional periodontal maintenance procedures (beyond 4 per calendar year)	Not Covered
	Periodontal Charting for Planning Treatment of Periodontal Disease	Not Covered		Periodontal charting for planning treatment of periodontal disease	Not Covered
	Periodontal Hygiene Instruction	Not Covered		Periodontal hygiene instruction	Not Covered
PROSTHETICS (Removable Tooth Replacement - Dentures) (Includes Up to 4 Adjustments Within First 6 Months After Insertion - Replacement Limit 1 Every 5 Years)			**Prosthetics (removable tooth replacement – dentures) includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years.**		
D5110	Full Upper Denture	$625.00	D5110	Full upper denture	$625.00
D5120	Full Lower Denture	$625.00	D5120	Full lower denture	$625.00
D5130	Immediate Full Upper Denture	$645.00	D5130	Immediate full upper denture	$680.00
D5140	Immediate Full Lower Denture	$645.00	D5140	Immediate full lower denture	$680.00
D5211	Upper Partial Denture - Resin Base (Including Clasps, Rests and Teeth)	$525.00	D5211	Upper partial denture – Resin base (including clasps, rests and teeth)	$525.00

D5212	Lower Partial Denture - Resin Base (Including Clasps, Rests and Teeth)	$525.00	D5212	Lower partial denture – Resin base (including clasps, rests and teeth)	$525.00
D5213	Upper Partial Denture - Cast Metal Framework (Including Clasps, Rests and Teeth)	$715.00	D5213	Upper partial denture – Cast metal framework (including clasps, rests and teeth)	$715.00
D5214	Lower Partial Denture - Cast Metal Framework (Including Clasps, Rests and Teeth)	$715.00	D5214	Lower partial denture – Cast metal framework (including clasps, rests and teeth)	$715.00
D5225	Upper Partial Denture - Flexible Base (Including Clasps, Rests and Teeth)	$575.00	D5225	Upper partial denture – Flexible base (including clasps, rests and teeth)	$605.00
D5226	Lower Partial Denture - Flexible Base (Including Clasps, Rests and Teeth)	$575.00	D5226	Lower partial denture – Flexible base (including clasps, rests and teeth)	$605.00
D5281	Removable Unilateral Partial Denture – One Piece Cast Metal Including Clasps and Teeth)	Not Covered	D5281	Removable unilateral partial denture – One piece cast metal including clasps and teeth)	Not Covered
D5410	Adjust Complete Denture Upper	$43.00	D5410	Adjust complete denture – Upper	$43.00
D5411	Adjust Complete Denture Lower	$43.00	D5411	Adjust complete denture – Lower	$43.00
D5421	Adjust Partial Denture Upper	$43.00	D5421	Adjust partial denture – Upper	$46.00
D5422	Adjust Partial Denture Lower	$43.00	D5422	Adjust partial denture – Lower	$46.00
D5850	Tissue Conditioning, Upper	Not Covered	D5850	Tissue conditioning – Upper	Not Covered
D5851	Tissue Conditioning, Lower	Not Covered	D5851	Tissue conditioning – Lower	Not Covered
D5862	Precision Attachment, By Report	Not Covered	D5862	Precision attachment – By report	Not Covered
REPAIRS TO PROSTHETICS			**Repairs to prosthetics**		
D5510	Repair Broken Complete Denture Base	$84.00	D5510	Repair broken complete denture base	$88.00
D5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	$72.00	D5520	Replace missing or broken teeth – Complete denture (each tooth)	$76.00
D5610	Repair Resin Denture Base	$84.00	D5610	Repair resin denture base	$88.00
D5620	Repair Cast Framework	Not Covered	D5620	Repair cast framework	Not Covered
D5630	Repair or Replace Broken Clasp	$105.00	D5630	Repair or replace broken clasp	$110.00
D5640	Replace Broken Teeth - Per Tooth	$77.00	D5640	Replace broken teeth – Per tooth	$81.00
D5650	Add Tooth to Existing Partial Denture	$84.00	D5650	Add tooth to existing partial denture	$88.00
D5660	Add Clasp to Existing Partial Denture	$105.00	D5660	Add clasp to existing partial denture	$110.00
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (Upper)	Not Covered	D5670	Replace all teeth and acrylic on cast metal framework – Upper	Not Covered
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Lower)	Not Covered	D5671	Replace all teeth and acrylic on cast metal framework – Lower	Not Covered
DENTURE RELINING (Limit 1 Every 36 Months)			**Denture relining (limit 1 every 36 months)**		
D5710	Rebase Complete Upper Denture	$235.00	D5710	Rebase complete upper denture	$250.00
D5711	Rebase Complete Lower Denture	$235.00	D5711	Rebase complete lower denture	$250.00
D5720	Rebase Upper Partial Denture	$235.00	D5720	Rebase upper partial denture	$250.00
D5721	Rebase Lower Partial Denture	$235.00	D5721	Rebase lower partial denture	$250.00
D5730	Reline Complete Upper Denture (Chairside)	$135.00	D5730	Reline complete upper denture – Chairside	$145.00
D5731	Reline Complete Lower Denture (Chairside)	$135.00	D5731	Reline complete lower denture – Chairside	$145.00
D5740	Reline Upper Partial Denture (Chairside)	$135.00	D5740	Reline upper partial denture – Chairside	$145.00
D5741	Reline Lower Partial Denture (Chairside)	$135.00	D5741	Reline lower partial denture – Chairside	$145.00
D5750	Reline Complete Upper Denture (Laboratory)	$200.00	D5750	Reline complete upper denture – Laboratory	$210.00
D5751	Reline Complete Lower Denture (Laboratory)	$200.00	D5751	Reline complete lower denture – Laboratory	$210.00
D5760	Reline Upper Partial Denture (Laboratory)	$200.00	D5760	Reline upper partial denture – Laboratory	$210.00
D5761	Reline Lower Partial Denture (Laboratory)	$200.00	D5761	Reline lower partial denture – Laboratory	$210.00
INTERIM DENTURES (Limit 1 Every 5 years)			**Interim dentures (limit 1 every 5 years)**		
D5810	Interim Complete Denture (Upper)	$300.00	D5810	Interim complete denture – Upper	$315.00
D5811	Interim Complete Denture (Lower)	$300.00	D5811	Interim complete denture – Lower	$315.00
D5820	Interim Partial Denture (Upper)	$265.00	D5820	Interim partial denture – Upper	$280.00
D5821	Interim Partial Denture (Lower)	$265.00	D5821	Interim partial denture – Lower	$280.00
Implant Services - Surgical Placement of Implants (D6010, D6012, D6040, and D6050 have a limit of 1 implant per calendar year with a replacement of 1 per 10 years)			**Implant Services - Surgical Placement of Implants (D6010, D6012, D6040, and D6050 have a limit of 1 implant per calendar year with a replacement of 1 per 10 years)**		
D6010	Surgical placement of implant body: Endosteal implant	Not Covered	D6010	Surgical placement of implant body: Endosteal implant	Not Covered
D6012	Surgical placement of interim implant body for transitional prosthesis: Endosteal implant	Not Covered	D6012	Surgical placement of interim implant body for transitional prosthesis: Endosteal implant	Not Covered
D6040	Surgical placement: Eposteal implant	Not Covered	D6040	Surgical placement: Eposteal implant	Not Covered
D6050	Surgical placement: Transosteal implant	Not Covered	D6050	Surgical placement: Transosteal implant	Not Covered

D6055	Connecting bar - Implant supported or abutment supported (limit 1 per calendar year)	Not Covered	D6055	Connecting bar - Implant supported or abutment supported (limit 1 per calendar year)	Not Covered
D6056	Prefabricated abutment - Includes modification and placement (limit 1 per calendar year)	Not Covered	D6056	Prefabricated abutment - Includes modification and placement (limit 1 per calendar year)	Not Covered
D6057	Custom fabricated abutment - Includes placement (limit 1 per calendar year)	Not Covered	D6057	Custom fabricated abutment - Includes placement (limit 1 per calendar year)	Not Covered
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis (limit 1 per calendar year)	Not Covered	D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis (limit 1 per calendar year)	Not Covered
D6090	Repair implant supported prosthesis, by report (limit 1 per calendar year)	Not Covered	D6090	Repair implant supported prosthesis, by report (limit 1 per calendar year)	Not Covered
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment (limit 1 per calendar year)	Not Covered	D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment (limit 1 per calendar year)	Not Covered
D6095	Repair implant abutment, by report (limit 1 per calendar year)	Not Covered	D6095	Repair implant abutment, by report (limit 1 per calendar year)	Not Covered
D6100	Implant removal, by report (limit 1 per calendar year)	Not Covered	D6100	Implant removal, by report (limit 1 per calendar year)	Not Covered
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure (limit 1 per calendar year)	Not Covered	D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure (limit 1 per calendar year)	Not Covered
D6102	Debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure (limit 1 per calendar year)	Not Covered	D6102	Debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure (limit 1 per calendar year)	Not Covered
D6103	Bone graft for repair of periimplant defect - not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration (limit 1 per calendar year)	Not Covered	D6103	Bone graft for repair of periimplant defect - not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration (limit 1 per calendar year)	Not Covered
D6104	Bone graft at time of implant placement (limit 1 per calendar year)	Not Covered	D6104	Bone graft at time of implant placement (limit 1 per calendar year)	Not Covered
D6190	Radiographic/surgical implant index, by report (limit 1 per calendar year)	Not Covered	D6190	Radiographic/surgical implant index, by report (limit 1 per calendar year)	Not Covered
ORAL SURGERY (Includes Routine Post-Operative Treatment). Surgical Removal of Impacted Tooth - Not Covered for Ages Below 15 Unless Pathology (disease) Exists.			**Oral surgery (includes routine postoperative treatment) Surgical removal of impacted tooth – Not covered for ages below 15 unless pathology (disease) exists.**		
D7111	Extraction of Coronal Remnants - Deciduous Tooth	$12.00	D7111	Extraction of coronal remnants – Deciduous tooth	$12.00
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$12.00	D7140	Extraction, erupted tooth or exposed root – Elevation and/or forceps removal	$12.00
D7210	Surgical Removal of Erupted Tooth - Removal of Bone and/or Section of Tooth	$50.00	D7210	Surgical removal of erupted tooth – Removal of bone and/or section of tooth	$53.00
D7220	Removal of Impacted Tooth - Soft Tissue	$43.00	D7220	Removal of impacted tooth – Soft tissue	$46.00
D7230	Removal of Impacted Tooth - Partially Bony	$86.00	D7230	Removal of impacted tooth – Partially bony	$91.00
D7240	Removal of Impacted Tooth - Completely Bony	$115.00	D7240	Removal of impacted tooth – Completely bony	$115.00
D7241	Removal of Impacted Tooth - Completely Bony, Unusual Complications (Narrative Required)	$115.00	D7241	Removal of impacted tooth – Completely bony, unusual complications (narrative required)	$125.00
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	$50.00	D7250	Surgical removal of residual tooth roots – Cutting procedure	$53.00
D7251	Coronectomy - Intentional Partial Tooth Removal	$86.00	D7251	Coronectomy – Intentional partial tooth removal	$91.00
D7260	Oroantral Fistula Closure	$115.00	D7260	Oroantral fistula closure	$125.00
D7261	Primary Closure of a Sinus Perforation	$115.00	D7261	Primary closure of a sinus perforation	$125.00
D7270	Tooth Stabilization of Accidentally Evulsed or Displaced Tooth	$13.00	D7270	Tooth stabilization of accidentally evulsed or displaced tooth	$14.00
D7280	Surgical Access of an Unerupted Tooth (Excluding Wisdom Teeth)	$13.00	D7280	Surgical access of an unerupted tooth (excluding wisdom teeth)	$14.00
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$7.00	D7283	Placement of device to facilitate eruption of impacted tooth	$8.00
D7285	Biopsy of Oral Tissue - Hard (Bone, Tooth) (Tooth Related - Not allowed when in conjunction with another surgical procedure)	$74.00	D7285	Biopsy of oral tissue – Hard (bone, tooth) (tooth related – not allowed when in conjunction with another surgical procedure)	$78.00
D7286	Biopsy of Oral Tissue - Soft (All Others) (Tooth Related - Not allowed when in conjunction with another surgical procedure)	$62.00	D7286	Biopsy of oral tissue – Soft (all others) (tooth related – not allowed when in conjunction with another surgical procedure)	$65.00
D7287	Exfoliative Cytological Sample Collection	$74.00	D7287	Exfoliative cytological sample collection	$78.00

D7288	Brush Biopsy - Transepithelial Sample Collection	$74.00	D7288	Brush biopsy – Transepithelial sample collection	$78.00
D7310	Alveoloplasty in Conjunction with Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	$55.00	D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$58.00
D7311	Alveoloplasty in Conjunction with Extractions - 1 to 3 Teeth or Tooth Spaces - Per Quadrant	$31.00	D7311	Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$33.00
D7320	Alveoloplasty Not in Conjunction with Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	$74.00	D7320	Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$78.00
D7321	Alveoloplasty Not in Conjunction with Extractions - 1 to 3 Teeth or Tooth Spaces - Per Quadrant	$38.00	D7321	Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$40.00
D7450	Removal of Benign Odontogenic Cyst or Tumor - Up to 1.25cm	$13.00	D7450	Removal of benign odontogenic cyst or tumor – Up to 1.25 cm	$14.00
D7451	Removal of Benign Odontogenic Cyst or Tumor - Greater Than 1.25cm	$13.00	D7451	Removal of benign odontogenic cyst or tumor – Greater than 1.25 cm	$14.00
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	$13.00	D7471	Removal of lateral exostosis – Maxilla or mandible	$14.00
D7472	Removal of Torus Palatinus	$13.00	D7472	Removal of torus palatinus	$14.00
D7473	Removal of Torus Mandibularis	$13.00	D7473	Removal of torus mandibularis	$14.00
D7485	Surgical Reduction of Osseous Tuberosity	$74.00	D7485	Surgical reduction of osseous tuberosity	$78.00
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	$13.00	D7510	Incision and drainage of abscess – Intraoral soft tissue	$14.00
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue Complicated	$19.00	D7511	Incision and drainage of abscess – Intraoral soft tissue – Complicated	$20.00
D7520	Incision and Drainage of Abscess – Extraoral Soft Tissue	Not Covered	D7520	Incision and drainage of abscess – Extraoral soft tissue	Not Covered
D7521	Incision and Drainage of Abscess – Extraoral Soft Tissue – Complicated (Includes Drainage of Multiple Fascial Spaces)	Not Covered	D7521	Incision and drainage of abscess – Extraoral soft tissue – Complicated (includes drainage of multiple fascial spaces)	Not Covered
D7880	Occlusal orthotic device, by report - (limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment)	Not Covered	D7880	Occlusal orthotic device, by report - (limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment)	$330.00
D7910	Suture of Recent Small Wounds up to 5cm	Not Covered	D7910	Suture of recent small wounds up to 5cm	Not Covered
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach (limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)	Not Covered	D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach (limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)	Not Covered
D7952	Sinus augmentation via a vertical approach (limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)	Not Covered	D7952	Sinus augmentation via a vertical approach (limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)	Not Covered
D7953	Bone replacement graft for ridge preservation - per site (limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)	Not Covered	D7953	Bone replacement graft for ridge preservation - per site (limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)	Not Covered
D7960	Frenulectomy - Also Known as Frenectomy or Frenotomy - Separate Procedure Not Incidental to Another	$13.00	D7960	Frenulectomy – Also known as frenectomy or frenotomy – Separate procedure not incidental to another procedure	$14.00
D7963	Frenuloplasty	$19.00	D7963	Frenuloplasty	$20.00
ORTHODONTICS (Tooth Movement) Orthodontic Treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)			**Orthodontics (tooth movement) Orthodontic treatment (maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)**		
D8050	Interceptive Orthodontic Treatment of the Primary Dentition (Banding)	$480.00	D8050	Interceptive orthodontic treatment of the primary dentition – Banding	$480.00
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition (Banding)	$480.00	D8060	Interceptive orthodontic treatment of the transitional dentition – Banding	$480.00
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition (Banding)	$500.00	D8070	Comprehensive orthodontic treatment of the transitional dentition – Banding	$500.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (Banding)	$515.00	D8080	Comprehensive orthodontic treatment of the adolescent dentition – Banding	$515.00
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition (Banding)	$515.00	D8090	Comprehensive orthodontic treatment of the adult dentition – Banding	$515.00
D8210	Removable Appliance Therapy	Not Covered	D8210	Removable appliance therapy	Not Covered
D8220	Fixed Appliance Therapy	Not Covered	D8220	Fixed appliance therapy	Not Covered
D8660	Pre-Orthodontic Treatment Visit	$67.00	D8660	Pre-orthodontic treatment visit	$67.00
D8670	Periodic Orthodontic Treatment Visit (As Part of Contract)		D8670	Periodic orthodontic treatment visit – As part of contract	$0.00
	Children (Up to 19th Birthday):			Children – Up to 19th birthday:	

	24 Month Treatment Fee	$2,045.00		24-month treatment fee	$2,040.00
	Charge Per Month for 24 Months	$85.00		Charge per month for 24 months	$85.00
	Adults:			Adults:	
	24 Month Treatment Fee	$2,385.00		24-month treatment fee	$2,376.00
	Charge Per Month for 24 Months	$99.00		Charge per month for 24 months	$99.00
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	$345.00	D8680	Orthodontic retention – Removal of appliances, construction and placement of retainer(s)	$345.00
D8693	Rebonding or Recementing; and/or Repair, As Required, of Fixed Retainers	Not Covered	D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	Not Covered
D8999	Unspecified Orthodontic Procedure, By Report (Orthodontic Treatment Plan and Records)	$195.00	D8999	Unspecified orthodontic procedure – By report (orthodontic treatment plan and records)	$195.00
ADJUNCTIVE SERVICES			**Adjunctive services**		
D9211	Regional Block Anesthesia	Not Covered	D9211	Regional block anesthesia	Not Covered
D9212	Trigeminal Division Block Anesthesia	Not Covered	D9212	Trigeminal division block anesthesia	Not Covered
D9215	Local Anesthesia	Not Covered	D9215	Local anesthesia	Not Covered
GENERAL ANESTHESIA / IV SEDATION - General Anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. IV Sedation is covered when performed by a Periodontist or Oral Surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. Plan limitation for this benefit is one hour per appointment. There is no coverage for general anesthesia or intravenous sedation when used for the purpose of anxiety control or patient management.			**General anesthesia / IV sedation – General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the patient charge schedule. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the patient charge schedule. Plan limitation for this benefit is 1 hour per appointment. There is no coverage for general anesthesia or IV sedation when used for the purpose of anxiety control or patient management.**		
D9220	General Anesthesia - First 30 Minutes	$180.00	D9220	General anesthesia – First 30 minutes	$190.00
D9221	General Anesthesia - Each Additional 15 Minutes	$80.00	D9221	General anesthesia – Each additional 15 minutes	$84.00
D9241	I.V. Conscious Sedation - First 30 Minutes	$180.00	D9241	IV conscious sedation – First 30 minutes	$190.00
D9242	I.V. Conscious Sedation - Each Additional 15 Minutes	$73.00	D9242	IV conscious sedation – Each additional 15 minutes	$73.00
D9610	Therapeutic Parenteral Drug, Single Administration	Not Covered	D9610	Therapeutic parenteral drug, single administration	Not Covered
D9612	Therapeutic Parenteral Drugs, Two or More Administrations, Different Medications	Not Covered	D9612	Therapeutic parenteral drugs, 2 or more administrations, different medications	Not Covered
D9630	Other Drugs and/or Medicaments, By Report	Not Covered	D9630	Other drugs and/or medicaments – By report	Not Covered
D9910	Application of Desensitizing Medicament	Not Covered	D9910	Application of desensitizing medicament	Not Covered
EMERGENCY SERVICES			**Emergency services**		
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	$0.00	D9110	Palliative (emergency) treatment of dental pain – Minor procedure	$0.00
D9120	Fixed Partial Denture Sectioning	Not Covered	D9120	Fixed partial denture sectioning	Not Covered
D9440	Office Visit - After Regularly Scheduled Hours	$53.00	D9440	Office visit – After regularly scheduled hours	$55.00
MISCELLANEOUS SERVICES External Bleaching (D9972) is limited to the use of take-home bleaching trays. All other bleaching methods are not covered.			**Miscellaneous services**		
D9940	Occlusal Guard - By Report (Limit 1 Per 24 Months)	$195.00	D9940	Occlusal guard – By report (limit 1 per 24 months)	$205.00
D9941	Fabrication of athletic mouthguard - (limit 1 per 12 months)	Not Covered	D9941	Fabrication of athletic mouthguard - (limit 1 per 12 months)	$110.00
D9942	Repair and/or Reline of Occlusal Guard	Not Covered	D9942	Repair and/or reline of occlusal guard	Not Covered
D9951	Occlusal Adjustment Limited	$38.00	D9951	Occlusal adjustment – Limited	$40.00
D9952	Occlusal Adjustment Complete	$200.00	D9952	Occlusal adjustment – Complete	$210.00
D9972	External Bleaching - Per Arch	$175.00	D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays (all other methods of bleaching are not covered)	$165.00
This may contain CDT codes and / or portions of, or excerpts from the Nomenclature contained within the Current Dental Terminology, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.			**This may contain CDT codes and / or portions of, or excerpts from the nomenclature contained within the Current Dental Terminology, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.**		

Cigna Dental Care® (*DHMO) Patient Charge Schedule

This Patient Charge Schedule lists the benefits of the Dental Plan including covered procedures and patient charges.

Important Highlights

- This Patient Charge Schedule applies only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Cigna Dental as described in your plan documents. Not all Network Dentists perform all listed services and it is suggested to check with your Network Dentist in advance of receiving services.
- This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made to a Network Specialty Periodontist, Orthodontist or Oral Surgeon. You must verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental. Prior authorization is not required for specialty referrals for Pediatric and Endodontic services. You may select a Network Pediatric Dentist for your child under the age of 7 by calling Customer Service at 1.800.Cigna24 to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 7th birthday.
- Procedures NOT listed on this Patient Charge Schedule are NOT covered and are the patient's responsibility at the dentist's usual fees.
- The administration of IV sedation, general anesthesia, and/or Nitrous Oxide is not covered except as specifically listed on this Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.
- Cigna Dental considers infection control and/or sterilization to be incidental to and part of the charges for services provided and not separately chargeable.
- This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract.

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Important Highlights *(continued)*

- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

Code	Procedure Description	Patient Charge
Office Visit Fee (Per patient, per office visit in addition to any other applicable patient charges)		
	Office Visit Fee	$5.00
Diagnostic/Preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic Oral Evaluations (D0120), Comprehensive Oral Evaluations (D0150), Comprehensive Periodontal Evaluations (D0180), and Oral Evaluations for Patients Under 3 Years of Age (D0145).		
D9310	Consultation (Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician)	$0.00
D9430	Office Visit for Observation – No Other Services Performed	$0.00
D9450	Case Presentation – Detailed and Extensive Treatment Planning	$0.00
D0120	Periodic Oral Evaluation – Established Patient	$0.00
D0140	Limited Oral Evaluation – Problem Focused	$0.00
D0145	Oral Evaluation for a Patient Under 3 Years of Age and Counseling with Primary Caregiver	$0.00
D0150	Comprehensive Oral Evaluation – New or Established Patient	$0.00
D0170	Re-evaluation – Limited, Problem Focused (Not Postoperative Visit)	$0.00
D0210	X-Rays Intraoral – Complete Series (Including Bitewings) *(Limit 1 Every 3 Years)*	$0.00
D0220	X-Rays Intraoral – Periapical – First Film	$0.00
D0230	X-Rays Intraoral – Periapical – Each Additional Film	$0.00
D0240	X-Rays Intraoral – Occlusal Film	$0.00
D0270	X-Rays (Bitewing) – Single Film	$0.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
D0272	X-Rays (Bitewings) – 2 Films	$0.00
D0273	X-Rays (Bitewings) – 3 Films	$0.00
D0274	X-Rays (Bitewings) – 4 Films	$0.00
D0277	X-Rays (Bitewings, Vertical) – 7 to 8 Films	$0.00
D0330	X-Rays (Panoramic Film) – *(Limit 1 Every 3 Years)*	$0.00
D0431	Oral Cancer Screening Using a Special Light Source	$50.00
D0460	Pulp Vitality Tests	$13.00
D0470	Diagnostic Casts	$0.00
D0472	Pathology Report – Gross Examination of Lesion (Only When Tooth Related)	$0.00
D0473	Pathology Report – Microscopic Examination of Lesion (Only When Tooth Related)	$0.00
D0474	Pathology Report – Microscopic Examination of Lesion and Area (Only When Tooth Related)	$0.00
D1110	Prophylaxis (Cleaning) – Adult *(Limit 2 per Calendar Year)*	$0.00
	Additional Prophylaxis (Cleaning) – In Addition to the 2 Prophylaxes (Cleanings) Allowed per Calendar Year	$45.00
D1120	Prophylaxis (Cleaning) – Child *(Limit 2 per Calendar Year)*	$0.00
	Additional Prophylaxis (Cleaning) – In Addition to the 2 Prophylaxes (Cleanings) Allowed per Calendar Year	$30.00
D1203	Topical Application of Fluoride – Child *(Up to 19th Birthday) (Limited to 2 per Calendar Year). There is a Combined Limit of a Total of 2 D1203s and/or D1206s per Calendar Year.*	$0.00
D1206	Topical Fluoride Varnish – Therapeutic Application for Moderate to High Caries Risk Patients – Child *(Up to 19th Birthday) (Limited to 2 per Calendar Year). There is a Combined Limit of a Total of 2 D1203s and/or D1206s per Calendar Year.*	$0.00
D1330	Oral Hygiene Instructions	$0.00
D1351	Sealant – Per Tooth	$11.00
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient – Permanent Tooth	$11.00
D1510	Space Maintainer – Fixed – Unilateral	$105.00
D1515	Space Maintainer – Fixed – Bilateral	$165.00
D1555	Removal of Fixed Space Maintainer	$0.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
Restorative (Fillings)		
D2140	Amalgam – 1 Surface, Primary or Permanent	$0.00
D2150	Amalgam – 2 Surfaces, Primary or Permanent	$0.00
D2160	Amalgam – 3 Surfaces, Primary or Permanent	$0.00
D2161	Amalgam – 4 or More Surfaces, Primary or Permanent	$0.00
D2330	Resin-Based Composite – 1 Surface, Anterior	$0.00
D2331	Resin-Based Composite – 2 Surfaces, Anterior	$0.00
D2332	Resin-Based Composite – 3 Surfaces, Anterior	$0.00
D2335	Resin-Based Composite – 4 or More Surfaces or Involving Incisal Angle, Anterior	$85.00
D2390	Resin-Based Composite Crown, Anterior	$85.00
D2391	Resin-Based Composite – 1 Surface, Posterior	$45.00
D2392	Resin-Based Composite – 2 Surfaces, Posterior	$57.00
D2393	Resin-Based Composite – 3 Surfaces, Posterior	$79.00
D2394	Resin-Based Composite – 4 or More Surfaces, Posterior	$110.00
Crown and Bridge – All charges for crown and bridge (fixed partial denture) are per unit (each replacement or supporting tooth equals 1 unit) – Replacement limit 1 every 5 years.		
D2510	Inlay – Metallic – 1 Surface	$400.00
D2520	Inlay – Metallic – 2 Surfaces	$400.00
D2530	Inlay – Metallic – 3 or More Surfaces	$400.00
D2542	Onlay – Metallic – 2 Surfaces	$460.00
D2543	Onlay – Metallic – 3 Surfaces	$460.00
D2544	Onlay – Metallic – 4 or More Surfaces	$460.00
D2740	Crown – Porcelain/Ceramic Substrate	$490.00
D2750	Crown – Porcelain Fused to High Noble Metal	$450.00
D2751	Crown – Porcelain Fused to Predominantly Base Metal	$400.00
D2752	Crown – Porcelain Fused to Noble Metal	$425.00
D2780	Crown – 3/4 Cast High Noble Metal	$450.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
D2781	Crown – 3/4 Cast Predominantly Base Metal	$400.00
D2782	Crown – 3/4 Cast Noble Metal	$425.00
D2790	Crown – Full Cast High Noble Metal	$450.00
D2791	Crown – Full Cast Predominantly Base Metal	$400.00
D2792	Crown – Full Cast Noble Metal	$425.00
D2794	Crown – Titanium	$450.00
D2910	Recement Inlay – Onlay or Partial Coverage Restoration	$42.00
D2915	Recement Cast or Prefabricated Post and Core	$42.00
D2920	Recement Crown	$42.00
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	$100.00
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	$100.00
D2932	Prefabricated Resin Crown	$130.00
D2933	Prefabricated Stainless Steel Crown with Resin Window	$160.00
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	$160.00
D2940	Protective Restoration	$12.00
D2950	Core Buildup – Including Any Pins	$130.00
D2951	Pin Retention – Per Tooth – In Addition to Restoration	$12.00
D2952	Post and Core – In Addition to Crown, Indirectly Fabricated	$160.00
D2954	Prefabricated Post and Core – In Addition to Crown	$130.00
D2960	Labial Veneer (Resin Laminate) – Chairside	$91.00
D6210	Pontic – Cast High Noble Metal	$450.00
D6211	Pontic – Cast Predominantly Base Metal	$400.00
D6212	Pontic – Cast Noble Metal	$425.00
D6214	Pontic – Titanium	$450.00
D6240	Pontic – Porcelain Fused to High Noble Metal	$450.00
D6241	Pontic – Porcelain Fused to Predominantly Base Metal	$400.00
D6242	Pontic – Porcelain Fused to Noble Metal	$425.00
D6245	Pontic – Porcelain/Ceramic	$445.00
D6602	Inlay – Cast High Noble Metal, 2 Surfaces	$450.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
D6603	Inlay – Cast High Noble Metal, 3 or More Surfaces	$450.00
D6604	Inlay – Cast Predominantly Base Metal, 2 Surfaces	$390.00
D6605	Inlay – Cast Predominantly Base Metal, 3 or More Surfaces	$390.00
D6606	Inlay – Cast Noble Metal, 2 Surfaces	$415.00
D6607	Inlay – Cast Noble Metal, 3 or More Surfaces	$425.00
D6610	Onlay – Cast High Noble Metal, 2 Surfaces	$440.00
D6611	Onlay – Cast High Noble Metal, 3 or More Surfaces	$450.00
D6612	Onlay – Cast Predominantly Base Metal, 2 Surfaces	$390.00
D6613	Onlay – Cast Predominantly Base Metal, 3 or More Surfaces	$390.00
D6614	Onlay – Cast Noble Metal, 2 Surfaces	$415.00
D6615	Onlay – Cast Noble Metal, 3 or More Surfaces	$425.00
D6624	Inlay – Titanium	$450.00
D6634	Onlay – Titanium	$450.00
D6740	Crown – Porcelain/Ceramic	$490.00
D6750	Crown – Porcelain Fused to High Noble Metal	$450.00
D6751	Crown – Porcelain Fused to Predominantly Base Metal	$400.00
D6752	Crown – Porcelain Fused to Noble Metal	$425.00
D6780	Crown – 3/4 Cast High Noble Metal	$450.00
D6781	Crown – 3/4 Cast Predominantly Base Metal	$400.00
D6782	Crown – 3/4 Cast Noble Metal	$425.00
D6790	Crown – Full Cast High Noble Metal	$450.00
D6791	Crown – Full Cast Predominantly Base Metal	$400.00
D6792	Crown – Full Cast Noble Metal	$425.00
D6794	Crown – Titanium	$450.00
	Complex Rehabilitation – ADDITIONAL CHARGE PER UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)*	$135.00
D6930	Recement Fixed Partial Denture	$59.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
Implant Supported Prosthetics – All charges for crown and bridge (fixed partial denture) are per unit (each replacement on a supporting implant(s) equals 1 unit) – Replacement limit 1 every 5 years. All charges for an implant supported denture are limited to replacement of 1 every 5 years.		
D6053	Implant/Abutment Supported Removable Denture for Completely Edentulous Arch	$925.00
D6054	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch	$1,015.00
D6058	Abutment Supported Porcelain/Ceramic Crown	$790.00
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	$750.00
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)	$700.00
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)	$725.00
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	$750.00
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	$700.00
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	$725.00
D6065	Implant Supported Porcelain/Ceramic Crown	$790.00
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$750.00
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$750.00
D6068	Abutment Supported Retainer for Porcelain/Ceramic Fixed Partial Denture	$790.00
D6069	Abutment Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (High Noble Metal)	$750.00
D6070	Abutment Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (Predominantly Base Metal)	$700.00
D6071	Abutment Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (Noble Metal)	$725.00
D6072	Abutment Supported Retainer for Cast Metal Fixed Partial Denture (High Noble Metal)	$750.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
D6073	Abutment Supported Retainer for Cast Metal Fixed Partial Denture (Predominantly Base Metal)	$700.00
D6074	Abutment Supported Retainer for Cast Metal Fixed Partial Denture (Noble Metal)	$725.00
D6075	Implant Supported Retainer for Ceramic Fixed Partial Denture	$790.00
D6076	Implant Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (Titanium, Titanium Alloy, High Noble Metal)	$750.00
D6077	Implant Supported Retainer for Cast Metal Fixed Partial Denture (Titanium, Titanium Alloy, High Noble Metal)	$750.00
D6078	Implant/ Abutment Supported Fixed Denture for Completely Edentulous Arch	$925.00
D6079	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch	$1,015.00
D6092	Recement Implant/Abutment Supported Crown	$82.00
D6093	Recement Implant/Abutment Supported Fixed Partial Denture	$99.00
D6094	Abutment Supported Crown (Titanium)	$750.00
D6194	Abutment Supported Retainer Crown for Fixed Partial Denture (Titanium)	$750.00
	Complex Rehabilitation on Implant Supported Prosthetic Procedures – ADDITIONAL CHARGE PER UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)*	$135.00
Endodontics (Root Canal Treatment, Excluding Final Restorations)		
D3110	Pulp Cap – Direct (Excluding Final Restoration)	$13.00
D3120	Pulp Cap – Indirect (Excluding Final Restoration)	$13.00
D3220	Pulpotomy – Removal of Pulp, Not Part of a Root Canal	$68.00
D3221	Pulpal Debridement (Not to be used when root canal is done on the same day)	$68.00
D3222	Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development	$68.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
D3310	Anterior Root Canal – Permanent Tooth (Excluding Final Restoration)	$210.00
D3320	Bicuspid Root Canal – Permanent Tooth (Excluding Final Restoration)	$245.00
D3330	Molar Root Canal – Permanent Tooth (Excluding Final Restoration)	$335.00
D3331	Treatment of Root Canal Obstruction – Nonsurgical Access	$92.00
D3332	Incomplete Endodontic Therapy – Inoperable, Unrestorable or Fractured Tooth	$92.00
D3333	Internal Root Repair of Perforation Defects	$92.00
D3346	Retreatment of Previous Root Canal Therapy – Anterior	$285.00
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid	$325.00
D3348	Retreatment of Previous Root Canal Therapy – Molar	$410.00
D3410	Apicoectomy/Periradicular Surgery – Anterior	$260.00
D3421	Apicoectomy/Periradicular Surgery – Bicuspid (First Root)	$290.00
D3425	Apicoectomy/Periradicular Surgery – Molar (First Root)	$320.00
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	$105.00
D3430	Retrograde Filling per Root	$68.00
Periodontics (Treatment of Supporting Tissues [Gum and Bone] of the Teeth) Periodontal regenerative procedures are limited to 1 regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. The Relevant Procedure Codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 Teeth (or 8 sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.		
D0180	Comprehensive Periodontal Evaluation – New or Established Patient	$32.00
D4210	Gingivectomy or Gingivoplasty – 4 or More Teeth per Quadrant	$170.00
D4211	Gingivectomy or Gingivoplasty – 1 to 3 Teeth per Quadrant	$86.00
D4240	Gingival Flap (Including Root Planing) – 4 or More Teeth per Quadrant	$220.00
D4241	Gingival Flap (Including Root Planing) – 1 to 3 Teeth per Quadrant	$115.00
D4245	Apically Positioned Flap	$220.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
D4249	Clinical Crown Lengthening – Hard Tissue	$240.00
D4260	Osseous Surgery – 4 or More Teeth per Quadrant	$400.00
D4261	Osseous Surgery – 1 to 3 Teeth per Quadrant	$225.00
D4263	Bone Replacement Graft – First Site in Quadrant	$290.00
D4264	Bone Replacement Graft – Each Additional Site in Quadrant	$225.00
D4266	Guided Tissue Regeneration – Resorbable Barrier per Site	$380.00
D4267	Guided Tissue Regeneration – Nonresorbable Barrier per Site (Includes Membrane Removal)	$430.00
D4270	Pedicle Soft Tissue Graft Procedure	$285.00
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	$295.00
D4275	Soft Tissue Allograft	$295.00
D4341	Periodontal Scaling and Root Planing – 4 or More Teeth per Quadrant *(Limit 4 Quadrants per Consecutive 12 Months)*	$83.00
D4342	Periodontal Scaling and Root Planing – 1 to 3 Teeth – per Quadrant *(Limit 4 Quadrants per Consecutive 12 Months)*	$42.00
D4355	Full Mouth Debridement to Allow Evaluation and Diagnosis *(1 per Lifetime)*	$62.00
D4381	Localized Delivery of Antimicrobial Agents per Tooth – By Report	$45.00
D4910	Periodontal Maintenance *(Limited to 2 per Calendar Year) (Only Covered after Active Therapy)*	$50.00
D9940	Occlusal Guard – By Report *(Limit 1 per 24 Months)*	$195.00
D9951	Occlusal Adjustment Limited	$38.00
D9952	Occlusal Adjustment Complete	$200.00
Prosthetics (Removable Tooth Replacement – Dentures) Includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years.		
D5110	Full Upper Denture	$625.00
D5120	Full Lower Denture	$625.00
D5130	Immediate Full Upper Denture	$645.00
D5140	Immediate Full Lower Denture	$645.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
D5211	Upper Partial Denture – Resin Base (Including Clasps, Rests and Teeth)	$525.00
D5212	Lower Partial Denture – Resin Base (Including Clasps, Rests and Teeth)	$525.00
D5213	Upper Partial Denture – Cast Metal Famework (Including Clasps, Rests and Teeth)	$715.00
D5214	Lower Partial Denture – Cast Metal Framework (Including Clasps, Rests and Teeth)	$715.00
D5225	Upper Partial Denture – Flexible Base (Including Clasps, Rests and Teeth)	$575.00
D5226	Lower Partial Denture – Flexible Base (Including Clasps, Rests and Teeth)	$575.00
D5410	Adjust Complete Denture – Upper	$43.00
D5411	Adjust Complete Denture – Lower	$43.00
D5421	Adjust Partial Denture – Upper	$43.00
D5422	Adjust Partial Denture – Lower	$43.00
Repairs to Prosthetics		
D5510	Repair Broken Complete Denture Base	$84.00
D5520	Replace Missing or Broken Teeth – Complete Denture (Each Tooth)	$72.00
D5610	Repair Resin Denture Base	$84.00
D5630	Repair or Replace Broken Clasp	$105.00
D5640	Replace Broken Teeth – Per Tooth	$77.00
D5650	Add Tooth to Existing Partial Denture	$84.00
D5660	Add Clasp to Existing Partial Denture	$105.00
Denture Relining (Limit 1 Every 36 Months)		
D5710	Rebase Complete Upper Denture	$235.00
D5711	Rebase Complete Lower Denture	$235.00
D5720	Rebase Upper Partial Denture	$235.00
D5721	Rebase Lower Partial Denture	$235.00
D5730	Reline Complete Upper Denture – Chairside	$135.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
D5731	Reline Complete Lower Denture – Chairside	$135.00
D5740	Reline Upper Partial Denture – Chairside	$135.00
D5741	Reline Lower Partial Denture – Chairside	$135.00
D5750	Reline Complete Upper Denture – Laboratory	$200.00
D5751	Reline Complete Lower Denture – Laboratory	$200.00
D5760	Reline Upper Partial Denture – Laboratory	$200.00
D5761	Reline Lower Partial Denture – Laboratory	$200.00
Interim Dentures (Limit 1 Every 5 Years)		
D5810	Interim Complete Denture – Upper	$300.00
D5811	Interim Complete Denture – Lower	$300.00
D5820	Interim Partial Denture – Upper	$265.00
D5821	Interim Partial Denture – Lower	$265.00
Oral Surgery (Includes Routine Postoperative Treatment) Surgical Removal of Impacted Tooth – Not covered for ages below 15 unless pathology (disease) exists.		
D7111	Extraction of Coronal Remnants – Deciduous Tooth	$12.00
D7140	Extraction, Erupted Tooth or Exposed Root – Elevation and/or Forceps Removal	$12.00
D7210	Surgical Removal of Erupted Tooth – Removal of Bone and/or Section of Tooth	$50.00
D7220	Removal of Impacted Tooth – Soft Tissue	$43.00
D7230	Removal of Impacted Tooth – Partially Bony	$86.00
D7240	Removal of Impacted Tooth – Completely Bony	$115.00
D7241	Removal of Impacted Tooth – Completely Bony, Unusual Complications (Narrative Required)	$115.00
D7250	Surgical Removal of Residual Tooth Roots – Cutting Procedure	$50.00
D7251	Coronectomy - Intentional Partial Tooth Removal	$86.00
D7260	Oroantral Fistula Closure	$115.00
D7261	Primary Closure of a Sinus Perforation	$115.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
D7270	Tooth Stabilization of Accidentally Evulsed or Displaced Tooth	$13.00
D7280	Surgical Access of an Unerupted Tooth *(Excluding Wisdom Teeth)*	$13.00
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$7.00
D7285	Biopsy of Oral Tissue – Hard (Bone, Tooth) *(Tooth Related – Not allowed when in conjunction with another surgical procedure)*	$74.00
D7286	Biopsy of Oral Tissue – Soft (All Others) *(Tooth Related – Not allowed when in conjunction with another surgical procedure)*	$62.00
D7287	Exfoliative Cytological Sample Collection	$74.00
D7288	Brush Biopsy – Transepithelial Sample Collection	$74.00
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces per Quadrant	$55.00
D7311	Alveoloplasty in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces per Quadrant	$31.00
D7320	Alveoloplasty Not in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces per Quadrant	$74.00
D7321	Alveoloplasty Not in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces per Quadrant	$38.00
D7450	Removal of Benign Odontogenic Cyst or Tumor – Up to 1.25 cm	$13.00
D7451	Removal of Benign Odontogenic Cyst or Tumor – Greater than 1.25 cm	$13.00
D7471	Removal of Lateral Exostosis – Maxilla or Mandible	$13.00
D7472	Removal of Torus Palatinus	$13.00
D7473	Removal of Torus Mandibularis	$13.00
D7485	Surgical Reduction of Osseous Tuberosity	$74.00
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	$13.00
D7511	Incision and Drainage of Abscess – Intraoral Soft Tissue Complicated	$19.00
D7960	Frenulectomy – Also Known as Frenectomy or Frenotomy – Separate Procedure Not Incidental to Another	$13.00
D7963	Frenuloplasty	$19.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
Orthodontics (Tooth Movement) Orthodontic Treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)		
D8050	Interceptive Orthodontic Treatment of the Primary Dentition – Banding	$480.00
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition – Banding	$480.00
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition – Banding	$500.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition – Banding	$515.00
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition – Banding	$515.00
D8660	Pre-Orthodontic Treatment Visit	$67.00
D8670	Periodic Orthodontic Treatment Visit – As Part of Contract	
	Children – Up to 19th Birthday:	
	24-Month Treatment Fee	$2,045.00
	Charge per Month for 24 Months	$85.00
	Adults:	
	24-Month Treatment Fee	$2,385.00
	Charge per Month for 24 Months	$99.00
D8680	Orthodontic Retention – Removal of Appliances, Construction and Placement of Retainer(s)	$345.00
D8999	Unspecified Orthodontic Procedure – By Report *(Orthodontic Treatment Plan and Records)*	$195.00

Cigna Dental Care®
Patient Charge Schedule (K1-V8)

Code	Procedure Description	Patient Charge
General Anesthesia/IV Sedation – General anesthesia is covered when performed by an Oral Surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. IV sedation is covered when performed by a Periodontist or Oral Surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. Plan limitation for this benefit is 1 hour per appointment. There is no coverage for general anesthesia or intravenous sedation when used for the purpose of anxiety control or patient management.		
D9220	General Anesthesia – First 30 Minutes	$180.00
D9221	General Anesthesia – Each Additional 15 Minutes	$80.00
D9241	IV Conscious Sedation – First 30 Minutes	$180.00
D9242	IV Conscious Sedation – Each Additional 15 Minutes	$73.00
Emergency Services		
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	$0.00
D9440	Office Visit – After Regularly Scheduled Hours	$53.00
Miscellaneous Services – External Bleaching (D9972) is limited to the use of take-home bleaching trays. All other bleaching methods are not covered.		
D9972	External Bleaching per Arch	$175.00

This may contain CDT codes and/or portions of, or excerpts from the Nomenclature contained within the *Current Dental Terminology*, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.

After your enrollment is effective:

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling Cigna Dental at the toll-free number listed on your ID card or plan materials.

Multiple ways to locate a *DHMO Network General Dentist:

- Online provider directory at www.Cigna.com
- Online provider directory on myCigna.com
- Call the number located on your ID card to:
  - Use the Dental Office Locator via Speech Recognition
  - Speak to a Customer Service Representative

EMERGENCY: If you have a dental emergency as defined in your group's plan documents, contact your Network General Dentist as soon as possible. If you are out of your service area or unable to contact your Network Office, emergency care can be rendered by any licensed dentist. Definitive treatment (e.g., root canal) is not considered emergency care and should be performed or referred by your Network General Dentist. Consult your group's plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.

*The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

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