

Individual Dental Insurance Policy

UnitedHealthcare Insurance Company

185 Asylum Street
Hartford, CT 06103-0450
1-(800) 232-5432

This Policy is entered into by UnitedHealthcare Insurance Company and the "Policyholder.

Upon our receipt of the signed *Application* and payment of the first Premium, this Policy is executed. The *Application* is made a part of this Policy.

We agree to provide Benefits for Covered Dental Care Services stated in this Policy, including the *Schedule of Covered Dental Care Services*, subject to the terms, conditions, exclusions, and limitations of this Policy.

This Policy continues in force by the timely payment of the required Premium when due, subject to the end of this Policy as provided in Article 5.

When this Policy ends, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date the Policy ends.

10 DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If you are not satisfied, you may notify us within 10 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

Check the attached application. If it is not complete or has an error, please let us know. An incorrect application may cause your Policy to be voided, or a claim to be reduced or denied.

Issued By:

UnitedHealthcare Insurance Company

Introduction to Your Policy

This *Policy* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

How Do You Use This Document?

Read your entire *Policy* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Policy* and *Schedule of Covered Dental Care Services* and any attachments in a safe place for your future reference.

Review the Benefit limitations of this *Policy* by reading the attached *Schedule of Covered Dental Care Services* along with *Section 1: Covered Dental Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 7: General Legal Provisions* to understand how this *Policy* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

For Dental Care Services rendered after the effective date of the Policy, this Policy replaces and supersedes any Policy, which may have been previously issued to you by the Company. Any subsequent Policy issued to you by the Company will in turn supersede this Policy.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call us at 1-800-445-9090. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Premiums

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your, including the eligibility requirements.
- You must qualify as a Covered Person or a Dependent as those terms are defined in *Section 9: Defined Terms*.

Be Aware the Policy Does Not Pay for All Dental Care Services

The Policy does not pay for all dental care services. Benefits are limited to Covered Dental Care Services. The *Schedule of Covered Dental Care Services* will tell you the portion you must pay for Covered Dental Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Dental Provider. We do not make decisions about the kind of care you should or should not receive.

Choose Your Dental Provider

It is your responsibility to select the dental care professionals who will deliver your care. We arrange for Dental Providers and other dental care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Dental Care Services require prior authorization. You are responsible for obtaining authorization before you receive the services. If you do not obtain prior authorization, we have a right to deny your claim for failure to comply with this requirement.

For detailed information on the Covered Dental Care Services that require prior authorization, please refer to the *Schedule of Covered Dental Care Services*.

Pay Your Share

You must meet any applicable Deductible and pay a Co-payment and/or Co-insurance for most Covered Dental Care Services. These payments are due at the time of service or when billed by the Dental Provider or facility. Any applicable Deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Covered Dental Care Services*. You must also pay any amount that exceeds the Allowed Amount.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

File Claims with Complete and Accurate Information

When you receive Covered Dental Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a dental care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the final authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Policy*, the *Schedule of Covered Dental Care Services* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Dental Care Services

We pay Benefits for Covered Dental Care Services as described in *Section 1: Covered Dental Care Services* and in the *Schedule of Covered Dental Care Services*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Dental Care Services. It also means that not all of the dental care services you receive may be paid for (in full or in part) by the Policy.

Pay Network Providers

It is the responsibility of Network Dental Providers and facilities to file for payment from us. When you receive Covered Dental Care Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Dental Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*. Your cost sharing may be more when you see an out-of-Network Dental Provider.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Dental Terminology* (a publication of the American Dental Association).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Dental Providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network Dental Providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Dental Provider or provider by contacting us at www.myuhc.com or by calling us at 1-800-445-9090.

Policy Table of Contents

Section 1: Covered Dental Care Services	8
Section 2: Exclusions and Limitations.....	11
Section 3: When Coverage Begins	14
Section 4: When Coverage Ends	16
Section 5: How to File a Claim	19
Section 6: Questions, Complaints and Appeals	21
Section 7: General Legal Provisions	23
Section 8: Premiums	31
Section 9: Defined Terms	33

Section 1: Covered Dental Care Services

When Are Benefits Available for Covered Dental Care Services?

Benefits are available only when all of the following are true:

- The dental care service, including supplies or pharmaceutical products, is only a Covered Dental Care Service if it is Necessary. (See definitions of Necessary and Covered Dental Care Service in *Section 9: Defined Terms*.)
- You receive Covered Dental Care Services while the Policy is in effect.
- You receive Covered Dental Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Dental Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease or its symptoms does not mean that the procedure or treatment is a Covered Dental Care Service under the Policy.

If we determine that a service, less costly than the Covered Dental Care Service the Dental Provider performed, could have been performed to treat a dental condition, we will pay Benefits based on the less costly service if such service:

- Would produce a professionally acceptable result under generally accepted dental standards and
- Would qualify as a Covered Dental Care Service

One example is:

- When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar. We may base our benefit determination on the amalgam filling which is the less costly service.

If we pay Benefits based on the less costly service, the Dental Provider may charge you or your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by a Network Dental Provider.

This section describes Covered Dental Care Services for which Benefits are available. Please refer to the attached *Schedule of Covered Dental Care Services* for details about:

- The amount you must pay for these Covered Dental Care Services (including any Deductibles, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Dental Care Services (frequency and dollar limits on services and/or materials and waiting periods).
- Any responsibility you have for obtaining prior authorization or notifying us.

1. Dental Benefits

Please check your *Schedule of Covered Dental Care Services* to verify what dental benefits are available to you.

2. Virtual Visits

Virtual visits for some Covered Dental Care Services through store and forward technologies, live consultation, and mobile health. This includes, but is not limited to, real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient dental information, including diagnostic-quality digital images and laboratory results for dental interpretation and diagnosis, for the purpose of delivering dental care services and information.

Coverage for Dental Care Services provided through virtual visits shall be equivalent to the Coverage for the same Services provided via face-to-face contact between a Dental Provider and a Covered Person. Nothing in this section shall require a Dental Provider to be physically present with the Covered Person.

We will not exclude a Dental Care Service for Coverage solely because such Dental Care Service is provided only through virtual visits and not through in-person consultation between the Covered Person and a Dental Provider, provided virtual visits are appropriate for the provision of such Dental Care Services.

Benefits are available only when services are delivered through a Network Dental Provider. You can find a Network Dental Provider by contacting us at www.myuhc.com or by calling us at 1-800-445-9090.

Please Note: Not all dental conditions can be treated through virtual visits. The Dental Provider will identify any condition for which treatment by in-person contact is needed.

Benefits do not include email, or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical and/or dental facilities.

3. Prenatal Dental Care

Any required Co-payment and/or Co-Insurance, Deductible, Waiting Period or Maximum Benefit is waived for a Covered Person through all trimesters of their pregnancy as well as three months post-delivery for the following Covered Dental Care Services:

- Prophylaxis – adult;
- Periodontal scaling and root planing - four or more teeth per quadrant;
- Periodontal scaling and root planing - one - three teeth per quadrant;
- Periodontal maintenance;
- Periodic oral evaluation;
- Radiographs;
- Lab and other diagnostic tests; and
- Full mouth debridement to enable comprehensive evaluation and diagnosis.

Pre-Treatment Estimate

If the charge for a Dental Care Service is expected to exceed \$500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Care Service under the Policy and estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-treatment estimate of benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment. The pre-treatment estimate is valid for 90 calendar days from the date we provide it to the Dental Provider. If you will not receive the services within the 90 calendar days, you or the Dental Provider must request another pre-treatment estimate from us.

Section 2: Exclusions and Limitations

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, and materials described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician or Dental Provider.
- It is the only available treatment for your condition.

The services, treatments, and materials listed in this section are not Covered Dental Care Services, except as may be specifically provided for in *Section 1: Covered Dental Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Dental Care Service categories, those limits are stated in the corresponding Covered Dental Care Service category in the *Schedule of Covered Dental Care Services*. Limits may also apply to some Covered Dental Care Services that fall under more than one Covered Dental Care Service category. When this occurs, those limits are also stated in the Schedule of Covered Dental Care Services table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Exclusions

Except as may be specifically provided in the *Schedule of Covered Dental Care Services* or through a Rider to the Policy, the following are not Covered Dental Care Services:

1. Dental Care Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any service done for cosmetic purposes that is not listed as a covered cosmetic service in the *Schedule of Covered Dental Care Services*.
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, or injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental or Investigational Service(s). Any treatment, device or pharmacological regimen that is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be an Experimental or Investigational Service.
8. Any implant procedures performed which are not listed as covered implant procedures in the *Schedule of Covered Dental Care Services*.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to you by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns, and implants, implant crowns, implant prostheses and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is due to patient non-compliance, the patient is liable for the cost of replacement.
14. Services other than those listed in the *Schedule of Covered Dental Care Services* for diagnosis and treatment of temporomandibular joint disorders (TMD).
15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice, or the notice period as required by the Dental Provider in question.
16. Expenses for Dental Procedures begun prior to you becoming enrolled under the Policy.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
18. Attachments to conventional removable prostheses or fixed bridgework. This includes, but is not limited to, semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
20. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
21. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Services rendered by a provider with the same legal residence as you or who is a member of your family, including but not limited to: spouse, brother, sister, parent or child.
24. Dental Care Services otherwise covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Care Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
25. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
26. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, surgical procedure to correct a malocclusion, replacement of lost or broken retainers, and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan within 120 months of initial or supplemental placement.
27. Foreign Services are not covered unless required as an Emergency.
28. Dental Care Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
29. Any Dental Care Services or Procedures not listed in the *Schedule of Covered Dental Care Services*.
30. Services rendered while covered under this Policy which were also covered by a prior carrier will be reviewed based on current Policy Coverage. Any Policy exclusions and/or limitations will apply based on when the Covered Dental Care Service was originally rendered, even when rendered while covered under a prior carrier.

31. Any Dental Care Service Covered under an essential health benefit plan is not covered under this Policy except for Orthodontic Dental Care Services.
32. Major restorative services relating to teeth that are not periodontally sound or that have a questionable prognosis of less than five years.

Section 3: When Coverage Begins

How Do You Enroll?

You must complete an application that we provide.

Effective Date

We have the right to accept or decline your application based upon information provided. Your insurance will become effective at 12:01 a.m. Central Standard Time on the effective date.

Who Is Eligible for Coverage?

If you apply for coverage, each of your eligible Dependents may also apply. A Dependent is eligible when he or she satisfies the Policy definition of Dependent.

No Dependent is eligible while on full-time active duty with a United States military service, military reserves, or National Guard, except when the duty is for less than 31 consecutive days.

We have the right to accept or decline your Dependent's application based on information on the completed application.

Eligible Persons must live within the United States.

Dependent Eligibility Date to Apply

Dependent generally refers to the Covered Person's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Adding New Dependents

Covered Persons may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

Initial Dependent Enrollment Period

An application that we provide must be completed. Your spouse and Dependent child(ren) over age 18 must also complete and sign the completed application if you are enrolling your spouse and Dependent child(ren) over age 18 for insurance. We must receive the completed application within 31 days from the Dependent eligibility date.

We have the right to accept or decline your Dependent's application based upon information provided. Application will not be denied for a newborn or adopted child if application is made within 31 days from the Dependent's eligibility date.

Late Enrollee for Dependent Insurance

If we receive the application after the initial Dependent application period, we have the right to decline the application based on the Dependent's application.

Dependent Effective Date

If you enroll the Dependent during the initial application period and we accept the Dependent for coverage, the Dependent's effective date will be the same as your effective date.

If you enroll the Dependent within 31 days from the Dependent's eligibility date, the Dependent's effective date will be:

1. In the case of marriage, the date of marriage;
2. In the case of a Dependent's birth, the date of such birth;
3. In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
4. In the case of a foster child, the date the foster child is placed in your home.

If you enroll the Dependent as a late enrollee after the Dependent's original application period and we accept the Dependent for coverage, the Dependent will become effective on the date we specify.

Your Dependent's insurance will become effective at 12:01 a.m. Central Standard Time on the effective date of coverage.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends. When your coverage ends, we will still pay claims for Covered Dental Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any dental care services received after that date.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Plan Renewals

Your Plan renews on each monthly Premium due date, subject to:

1. The Termination of Insurance provisions in the Policy; and
2. Our right to change Premiums as described in the Premium Changes section in the Policy.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

1. The date the Policy is terminated by the Policyholder or by us;
2. The date you fail to pay us the required Premiums and/or fees by the due date, subject to the Grace Period provision;
3. The date you perform an act or practice that is fraudulent, or made an intentional misrepresentation of a material fact under the terms of insurance under the Plan;
4. The date you move to a state where we are not authorized to do business or are not actively marketing;
5. The date we discontinue offering and renewing all individual dental coverage in your state. If this happens, we will notify you at least 180 days in advance; or
6. The date of your death. .

The termination date for the above events (1 through 5) is the first of the month following the termination event.

Insurance will terminate at 12:01 a.m. Central Standard Time on the termination date of coverage.

However, if the termination is due to fraud or an intentional misrepresentation of a material fact under the terms of insurance under the Plan, we may void the insurance. Void means that the insurance was never in effect.

If we void insurance, we will return to you all Premiums we received, less the amount of any claims we paid, for you and your insured Dependents under the Plan. We reserve the right to recover any claims amount that exceeds the Premiums we received.

What Events End Your Dependents Coverage?

Insurance terminates for a Dependent when the first of the following events happens:

1. The date you request termination of insurance for a Dependent. You may terminate insurance at any time by providing us with written notice prior to the requested termination date;
2. The due date we do not receive the required Premium for the Dependent;
3. The date the Dependent no longer satisfies the Policy definition of Dependent;
4. For an adopted child, the date placement is terminated and the adoption is not made final;
5. For a foster child, the date foster care is terminated;
6. For a child for whom you have legal guardianship, the date guardianship terminates;
7. The date your Dependent performs an act or practice that is fraudulent, or makes an intentional misrepresentation of a material fact under the terms of insurance under the Plan; or
8. The date of your Dependent's death.

The termination date for the above events (1 through 7) is the first of the month following the termination event.

Insurance will terminate at 12:01 a.m. Central Standard Time on the termination date.

However, if the termination is due to fraud or an intentional misrepresentation of a material fact under the terms of insurance under the Plan, we may void the insurance. Void means that the insurance was never in effect.

Notification of Plan Termination

We will notify you when the Plan terminates due to any of the reasons listed in the Termination of Insurance section in the Policy.

Reinstatement

Insurance terminated for the Policyholder may be reinstated subject to Our written approval and receipt of all required Premiums. Reinstatement is limited to once every 12 months. The insurance is effective on the date of reinstatement unless we specify another date.

Reapplying after Termination

If you terminate Coverage, you must wait until the following open enrollment period until you may again apply for Coverage.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental or physical handicap or disability.
- The Enrolled Dependent child depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Continuing Eligibility

For Dependent spouse: A spouse will cease to be a Covered Person at the end of the premium period in which they cease to be your spouse due to a divorce.

We must receive notification within 90 days of the date a covered spouse ceases to be an eligible Covered Person. If notice is received by us more than 90 days from this date, any unearned premium will be credited only from the first day of the Policy month in which we receive notice.

Continuation of Coverage

If your spouse ceases to be a Covered Person due to the fact that he or she no longer meets the definition of Dependent under the policy, your former spouse may be eligible for continuation of coverage based on your former spouse's residence. If available where your former spouse resides, we will continue your former spouse's coverage by issuing a separate new policy. The new policy and premium rates will be determined based on the residence of your former spouse. All other terms and conditions of the new policy, as applicable to your former spouse, will be the same as applicable to your spouse under this policy, unless otherwise mandated by the state in which your former spouse resides. Any Deductibles, Waiting Periods, Maximum Benefit, and Maximum Policy Benefit limits will be satisfied under the new policy to the extent satisfied under this policy at the time that the continuation of coverage is issued.

Notification Requirements

It is your or your former spouse's responsibility to notify us within 90 days of your legal divorce. You must notify us of the address at which the continuation of coverage should be issued.

We will issue the continuation of coverage within 30 days after the date we receive timely notice of your legal divorce. Your former spouse must pay the required premium within 31 days following notice from us or the new policy will be void from its beginning.

Continuing Eligibility

For Dependent children. A Dependent child will cease to be a Covered Person at the end of the premium period in which they cease to meet the definition of Dependent.

We must receive notification within 90 days of the date a Covered Person ceases to be an eligible child. If notice is received by us more than 90 days from this date, any unearned premium will be credited only from the first day of the calendar month in which we receive the notice.

We reserve the right to issue a new policy with the same benefits as this policy to an eligible child who reaches the limiting age of 26.

A Dependent child will not cease to be an eligible Dependent solely because of age if the eligible child meets the criteria listed in Coverage for a Disabled Dependent Child

Section 5: How to File a Claim

How Are Covered Dental Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Dental Care Services. If a Network provider bills you for any Covered Dental Care Service, contact us. However, you are required to meet any applicable Deductible and to pay any required Co-payments and Co-insurance to a Network provider. You will also be responsible for any charges that are not covered by the Policy to your Dental Provider.

How Are Covered Dental Care Services from an Out-of-Network Provider Paid?

When you receive Covered Dental Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that dental care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Covered Person's name, address and age.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider(s) including a complete dental chart showing extractions, fillings or other Dental Care Services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports, as applicable.
- Casts, molds or study models, as applicable.
- An itemized bill which includes the CDT Codes or a description of each charge.
- The date the dental disease began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other dental plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at Claims Department, P.O. Box 30978, Salt Lake City, UT 84130 or by fax to 248-733-6060. If you would like to use a claim form, you may access a form on the Internet at www.myuhc.com or call us at 1-800-445-9090 and a claim form will be provided to you.

Proof of Loss. Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

Payment of Benefits

If you provide written authorization to allow this, all or a portion of any Allowed Amounts due to a provider may be paid directly to the provider instead of being paid to the Policyholder. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other Dental Providers.

Benefits will be paid to you unless either of the following is true:

- The Dental Provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Contact Customer Service at 1-800-445-9090. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Contact Customer Service at 1-800-445-9090. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after dental care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving dental care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of dental care service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a dental care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask dental experts to take part in the appeal process. You consent to this referral and the sharing of needed dental claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dental Provider should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Dental Provider to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Section 7: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to this Policy and how it may affect you. We help finance or administer this Policy. We do not provide dental care services or make treatment decisions.

This means:

- We communicate decisions about whether the Policy will cover or pay for the dental care that you may receive. The Policy pays for Covered Dental Care Services, which are described within this Policy and the *Dental Schedule of Covered Dental Care Services*.
- The Policy may not pay for all dental care services or materials you or your Dental Provider may believe are needed. If the Policy does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers?

The relationships between us and Network Dental Providers are solely contractual relationships between independent contractors. Network Dental Providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network Dental Providers.

We do not provide dental care services or supplies, or practice medicine. We arrange for dental providers to participate in a Network and we pay Benefits. Network Dental Providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not responsible for any act or omission of any dental provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under this Policy.

What Is Your Relationship with Providers?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own Dental Provider.
- Paying, directly to your Dental Provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any Deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your Dental Provider, the cost of any non-Covered Dental Care Service.
- Deciding if any provider treating you is right for you. This includes Network Dental Providers you choose and Dental Providers that they refer.
- Deciding with your Dental Provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

Notice

We may from time to time provide written notice regarding administration of the Policy to you. The notice is deemed notice to you and your Enrolled Dependents.

Statements by Policyholder

All statements made by the Policyholder in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Policyholder to void the Policy after it has been in force for two years unless it is a fraudulent statement.

Who Interprets Benefits and Other Provisions under the Policy?

We have the final authority to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in this Policy, the *Schedule of Covered Dental Care Services* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Dental Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Policy's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning dental care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your dental records or billing statements you may contact your Dental Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request dental forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Dental Provider of our choice examine you at our expense.

Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

We have the right to subrogation and reimbursement. References to “you” or “your” in this *Subrogation and Reimbursement* section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when we have paid Benefits on your behalf for a sickness or injury for which any third party is allegedly responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the sickness or injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you receive for that sickness or injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- Your employer in a workers’ compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
 - Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.
- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits we have paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness or injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Policy is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the policyholder, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Is There a Time Limit on Certain Defenses?

No statement made by the Policyholder, except a fraudulent statement, can be used to void this Policy after it has been in force for a period of two years.

What Is the Entire Policy?

This Policy, the *Schedule of Covered Dental Care Services*, the *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Policyholder.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of Coverage under the Policy. A clerical error also does not create a right to benefits.

Other Insurance for Dental care services

If any Covered expenses under this Policy are also payable under health or other dental insurance or other health coverage, we will not make payment under this dental Policy until after we determine what benefits are paid or payable by the health insurance or other dental or health coverage plan.

Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to follow the minimum requirements of those statutes and regulations.

Section 8: Premiums

Premium Payments

We must receive the required Premiums by the due date. The first payment is due on the effective date. Unless we specify otherwise, the due date for each Premium payment thereafter is the first day of each calendar month.

This Plan may require monthly, quarterly, semi-annual, or annual Premium payment. Failure to pay accordingly may result in termination of the Policy.

Administrative, service, and/or policy fees, where allowable by law, are due and payable on the due date. If fees are not paid, the Policy may be subject to termination.

We have the right to charge a fee for late payment.

All payments shall be made in United States currency, in immediately available funds, and shall be sent to us at the address on the invoice, or at another address that we may designate in writing.

Does a Grace Period Apply?

You have a 31 day grace period for the payment of each Premium due after the first Premium. Your coverage will continue in force during the grace period unless you have given us prior written notice of termination. If such a Premium is not received by us by the end of the grace period, the policy will terminate at the end of the grace period. We reserve the right to recover any amounts Incurred and paid during the grace period.

Premium Changes

Premium rates are calculated based on a variety of factors. As allowed by state law, these factors may include geographic location, provider network, distribution channels, selected benefits, age, gender, tobacco use, classes, health status of you and your insured Dependents, length of time you are insured under the plan, health status of the entire pool of insureds in which you are included, administrative costs, occupation, industry, and other factors.

Your Premium rates, administrative fees and/or service fees are guaranteed for 12 months from your coverage effective date, except when:

1. Your residence changes;
2. You or your insured Dependent attain a higher age;
3. A Dependent is added to or terminated from the plan; or
4. Any benefit is changed including, but not limited to, increases or decreases in a benefit or the addition or removal of a benefit from the plan.

We reserve the right to change the Premium rates, the administrative fees, and/or the service fees on the next Premium due date when one of the above-mentioned events occurs. We will notify you about the change as soon as possible.

Premiums, administrative fees and/or service fees may also change at your renewal date. We will provide you with advance written notice a minimum of 30 days prior to the effective date of the change unless state law requires additional notice.

If we find that Premiums, administrative fees, and/or service fees are incorrect, we will:

1. Make a refund to you for any amount of overpaid Premiums; or
2. Request a payment from you for any amount of underpaid Premiums.

Return of Premium for Voided Insurance

We may void insurance for you or your Dependent as allowed under the Time Limit on Certain Defenses provision of this Policy. When this happens:

1. If we did not receive any claims for you or your Dependent prior to the void date, we will refund all Premiums paid for you or your Dependent; or
2. If we received claims that we must pay for you or your Dependent prior to the void date, we reserve the right to subtract from the refund the amount of claims that we must pay.

We reserve the right to recover the amount of any claims we paid or costs incurred by us that exceed the Premium refund.

Section 9: Defined Terms

Allowed Amounts – Allowed Amounts for Covered Dental Care Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Care Services with that Dental Provider and any Usual and Customary fees for Orthodontic Services.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Benefits - your right to payment for Covered Dental Care Services that are available under the Policy.

CDT Codes mean the Current Dental Terminology for the current Code on Dental Procedures and Nomenclature (the Code). The Code has been designated as the national standard for reporting dental care services by the Federal Government under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), and is currently recognized by third party payors nationwide.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Dental Care Services.

Please note that for Covered Dental Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Dental Care Service(s) or Dental Procedures- dental care services, including supplies or materials, which we determine to be all of the following:

- Necessary.
- Treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.
- Described as a Covered Dental Care Service in this *Policy* under *Section 1: Covered Dental Care Services* and in the *Schedule of Covered Dental Care Services*.
- Not excluded in this *Policy* under *Section 2: Exclusions and Limitations*.

Covered Person - the Policyholder or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Policy* to refer to a Covered Person.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Care Services, perform dental surgery or administer anesthetics for dental surgery.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. To be eligible for Coverage under the Policy, a Dependent must reside within the United States. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.
- A child for whom dental care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order.

The following conditions apply:

- A Dependent includes a an unmarried child listed above under age 26.
- A Dependent includes a an unmarried child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 26, except as provided in *Section 4: When Coverage Ends* under Coverage for a Disabled Dependent Child

The Covered Person must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Covered Person. No one can be a Dependent of more than one Covered Person.

Eligible Person - a person who meets the eligibility requirements specified in the application and the Policy.

Emergency - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Experimental or Investigational Service(s) - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
- Pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that sickness or condition.

Foreign Services –services provided outside the U.S. and U.S. territories.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Natural Tooth/Teeth - sound Natural Teeth are defined as teeth that are free of any pathological, functional or structural disorders at the time of injury and not having had any restorative treatment including, but not limited to fillings, root canals, crowns, caps and orthodontia in place at the time of trauma.

Necessary - Dental Care Services and supplies which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate; and

- A. needed to meet your basic dental needs; and
- B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Care Service; and
- C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us; and
- D. consistent with the diagnosis of the condition; and
- E. required for reasons other than the convenience of you or your Dental Provider; and
- F. demonstrated through prevailing peer-reviewed dental literature to be either:
 - 1. safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; or
 - 2. safe with promising efficacy:
 - a. for treating a life threatening dental disease or condition; and
 - b. in a clinically controlled research setting; and
 - c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Care Service as defined in this *Policy*. The definition of Necessary used in this *Policy* relates only to Coverage and differs from the way in which a Dental Provider engaged in the practice of dentistry may define Necessary.

Network - when used to describe a provider of dental care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Dental Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Dental Care Services, but not all Covered Dental Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Dental Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Dental Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Dental Care Services provided by Network providers. The *Schedule of Covered Dental Care Services* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Plan Year - The period of time, usually beginning with the Policy's effective date of any year and terminating on the same date of the succeeding year, when accumulators for applicable Deductibles and plan maximums are calculated. If the Policy effective date is February 29, such date will be considered to be February 28 in any year having no such date.

Policy - the entire agreement issued to the Policyholder that includes all of the following:

- *Policy.*
- *Schedule of Covered Dental Care Services.*
- *Application.*
- *Riders.*
- *Amendments.*

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - means the person to whom the Policy is issued.

Premium - the periodic fee required for each Covered Person and each Enrolled Dependent, in accordance with the terms of the Policy.

Rider - any attached written description of additional Covered Dental Care Services not described in this *Policy*. Covered Dental Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Usual and Customary - Usual and Customary fees are calculated by us based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the Dental Provider would charge any similarly situated payor for the same services. In the event that a Dental Provider routinely waives Co-payments, Co-Insurance, and/or the applicable Deductible for benefits, Dental Care Services for which the Co-payments, Co-Insurance and/or the applicable Deductible are waived are not considered to be Usual and Customary.

Usual and Customary fees are determined solely in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed by us, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Dental Terminology*, a publication of the *American Dental Association*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination accepted by us.

Schedule of Covered Dental Care Services

How Do You Access Benefits?

This Schedule of Covered Dental Care Services: (1) describe the Covered Dental Care Services and any applicable limitations to those services; (2) outline the Co-payments that you are required to pay for each Covered Dental Care Service.

Network Dental Providers

We have arranged with certain Dental Providers to participate in a Network. These Network Dental Providers have agreed to discount their charges for Covered Dental Care Services and supplies.

If Network Dental Providers are used, the amount of Covered expenses for which you are responsible will generally be less than the amount owed if out-of-Network Dental Providers had been used. The Co-payment level remains the same whether or not Network Dental Providers are used. However, because the total charges for Covered expenses may be less when Network Dental Providers are used, the portion that you owe will generally be less.

Directory of Network Dental Providers

A Directory of Network Dental Providers will be made available. You may access the Directory of Network Dental Providers online at www.myuhc.com. You can also call customer service to determine which Dental Providers participate in the Network at 1-800-445-9090.

Network Benefits

This Schedule of Covered Dental Care Services describes benefit levels available under the Policy.

Network Benefits

Dental Care Services must be provided by a Network Dental Provider in order to be considered Network Benefits. When Covered Dental Care Services are received from a Network Dental Provider, Allowed Amounts are our contracted fee(s) with that provider.

The only exception is if you need Emergency care and you are out of your service area or are unable to contact your Network general Dental Provider. In this situation, Emergency care will be covered as a Network Benefit and you will not be responsible for greater out-of-pocket expenses than if you had attended a Network Dental Provider. You must submit appropriate reports and x-rays.

When Dental Care Services are received from an out-of-Network Dental Provider as a result of an Emergency, the Co-payment will be the Network Co-payment.

Covered Dental Care Services must be provided by or directed by a Network Dental Provider.

Enrolling for Coverage under the Policy does not guarantee dental care services by a particular Network Dental Provider on the list of Dental Providers. The list of Network Dental Providers is subject to change. When a Dental Provider on the list no longer has a contract with us, you must choose among remaining Network Dental Providers. You are responsible for verifying the Network participation status of your Dental Provider, prior to receiving such Dental Care Services.

If you fail to verify whether your treating Dental Provider's participation in the Network, and the failure results in non-compliance with our required procedures, Coverage of Network Benefits may be denied.

Coverage for Dental Care Services is subject to payment of the Premium required for Coverage under the Policy and payment of the Co-payment specified for any service. Network Benefits are determined based on the contracted fee for each Covered Dental Care Service. In no event will you be required to pay a Network Dental Provider an amount for a Covered Dental Care Service in excess of the contracted fee.

A Network Dental Provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network Dental Provider may charge you. However, these charges will not be considered Covered Dental Care Services and will not be payable by us.

Covered Dental Care Services are subject to payment of any Co-payments as stated below.

The following definitions apply for this plan.

General Dental Provider - a Dental Provider who provides general Dental Care Services.

Specialty Dental Provider- a Dental Provider who provides specialized Dental Care Services.

Specialty Referral - A referral for Dental Care Services for endodontics, oral surgery, pediatric dentistry, orthodontics and periodontics.

Specialty Services

1. This Covered Person's Schedule of Covered Dental Care Services applies when listed Dental Care Services are performed by a Network General Dental Provider, unless otherwise authorized.
2. Procedures not listed on the Schedule of Covered Dental Care Services that are performed by a Network General Dental Provider will be charged at the Network General Dental Provider's Usual and Customary fee less 25%.
3. The Network General Dental Provider you select may not perform all procedures listed. The Co-payments shown apply to Network General Dental Providers.
4. Should the Dental Care Services of a specialist (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dental Provider) be Necessary, you may receive this care in either of two ways: (1) You may go directly to a Network Specialty Dental Provider with no referral and receive a 25% reduction off the Specialty Dental Provider's Usual and Customary fee; or (2) You may obtain prior written authorization from us and receive specialty treatment by an approved Network Specialty Dental Provider at the listed Co-payments.
5. Should the Dental Care Services of an Orthodontist be Necessary, you may receive care in either of two ways: (1) You may go directly to a Network Specialty Dental Provider with no referral and receive a 25% reduction off the Specialty Dental Provider's Usual and Customary fee; or (2) You may contact Customer Service to locate your nearest Network Orthodontist who will perform Covered Dental Care Services at the listed Covered Person's Co-payment.
6. Covered Person's seeking implant treatment should refer to their Network implantologist, a select Network of Dental Providers. Not all Dental Providers perform the implant procedures at the Co-payment listed on the Schedule of Covered Dental Care Services.

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
DIAGNOSTIC SERVICES		
D0120	Periodic Oral Evaluation - Established Patient Limited to 1 time per consecutive 6 months. All subsequent oral evaluations will be at 25% reduction off the Dentist's usual and customary fee without a frequency limitation.	\$0
D0140	Limited Oral Evaluation - Problem Focused Limited to 1 time per consecutive 6 months. Only 1 exam is covered per date of service. All subsequent oral evaluations will be at 25% reduction off the Dentist's usual and customary fee without a frequency limitation.	\$0
D0145	Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver Limited to new patients or 1 time per consecutive 6 months for established patients. Not covered if done in conjunction with other exams. All subsequent oral evaluations will be at 25% reduction off the Dentist's usual and customary fee without a frequency limitation.	\$0
D0150	Comprehensive Oral Evaluation - New or Established Patient Limited to new patients or 1 time per consecutive 6 months for established patients. Not covered if done in conjunction with other exams. All subsequent oral evaluations will be at 25% reduction off the Dentist's usual and customary fee without a frequency limitation.	\$0
D0160	Detailed and Extensive Oral Evaluation - Problem-Focused, by report Limited to 1 per consecutive 6 months. Only 1 exam is Covered per date of service. All subsequent oral evaluations will be at 25% reduction off the Dentist's usual and customary fee without a frequency limitation.	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D0170	Re-Evaluation, Limited, Problem Focused (Established Patient; Not Post - Operative Visit) Limited to 1 per consecutive 6 months. All subsequent oral evaluations will be at 25% reduction off the Dentist's usual and customary fee without a frequency limitation.	\$0
D0171	Re-Evaluation - Post Operative Office Visit Limited to 1 per consecutive 6 months.	\$0
D0180	Comprehensive Periodontal Evaluation - New or Established patient Limited to 1 per consecutive 36 months. All subsequent oral evaluations will be at 25% reduction off the Dentist's usual and customary fee without a frequency limitation.	\$0
D0210	Intraoral - Complete Series of Radiographic Images Limited to 1 time per consecutive 5 years. Vertical bitewings cannot be billed in conjunction with a complete series. Intraoral- Complete Series D0210 or Panoramic Radiograph Image D0330 are reimbursable 1 time per consecutive 5 years. D0210, D0274, or D0277 are payable only when other inclusive images have not been taken (paid) within the last 6 months.	\$0
D0220	Intraoral - Periapical – First Radiographic Image	\$4
D0230	Intraoral - Periapical - Each Additional Radiographic Image	\$2
D0240	Intraoral - Occlusal Radiographic Image	\$0
D0250	Extra-Oral - 2D Projection Radiographic Image Created Using a Stationary Radiation Source, and Detector	\$0
D0251	Extra-Oral Posterior Dental Radiographic Image	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D0270	Bitewing – Single Radiograph Image Limited to 4 images per consecutive 12 months. All bitewing x-rays are limited to one set in any consecutive 12 months period.	\$0
D0272	Bitewings - Two Radiograph Images Limited to 2 images per consecutive 12 months. All bitewing x-rays are limited to one set in any consecutive 12 months period.	\$0
D0273	Bitewings - Three Radiograph Images Limited to 1 series of images per consecutive 12 months. All bitewing x-rays are limited to one set in any consecutive 12 months period.	\$0
D0274	Bitewings - Four Radiograph Images Limited to 1 series of images per consecutive 12 months. D0210, D0274, or D0277 are payable only when other inclusive images have not been taken (paid) within the last 6 months.	\$0
D0277	Vertical Bitewings, 7-8 Radiograph Images Limited to 1 series of images per consecutive 12 months. D0210, D0274, or D0277 are payable only when other inclusive images have not been taken (paid) within the last 6 months.	\$32
D0310	Sialography	\$150
D0330	Panoramic Radiograph Image Limited to 1 time per consecutive 5 years. Intraoral- Complete Series D0210 or Panoramic Radiograph Image D0330 are reimbursable 1 time per consecutive 5 years.	\$50
D0340	2D Cephalometric Radiographic Image – Acquisition, Measurement and Analysis	\$162

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D0350	2D Oral/Facial Photographic Images Obtained Intra-Orally or Extra-Orally.	\$20
D0364	Cone Beam CT Capture and Interpretation with Limited Field of View – Less than One Whole Jaw D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$152
D0365	Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch-Mandible D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$142
D0366	Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch-Maxilla, With and Without Cranium D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$142
D0367	Cone Beam CT Capture and Interpretation with Field of View of Both Jaws, With and Without Cranium D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$187
D0368	Cone Beam CT Capture and Interpretation for TMJ Series Including Two or More Exposures D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$142
D0369	Maxillofacial MRI Capture and Interpretation D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$192
D0370	Maxillofacial Ultrasound Capture and Interpretation D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$172

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D0371	Sialoendoscopy Capture and Interpretation D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$172
D0372	Intraoral - Complete Series of Radiographic Images Limited to 1 time per consecutive 5 years. Vertical bitewings cannot be billed in conjunction with a complete series.	\$0
D0373	Bitewings - Four Radiograph Images Limited to 1 series of images per consecutive 12 months.	\$0
D0374	Intraoral - Periapical – First Radiographic Image	\$4
D0380	Cone Beam CT Image Capture with Limited of Field of View – Less than One Whole Jaw D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$152
D0381	Cone Beam CT Image Capture with Field of View of One Full Dental Arch – Mandible D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$142
D0382	Cone Beam CT Image Capture with Field of View of One Full Dental Arch – Maxilla, with or without Cranium D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$142
D0383	Cone Beam CT Image Capture with Field of View of Both Jaws, with or without Cranium D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$187

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D0384	Cone Beam CT Image Capture for TMJ Series Including Two or More Exposures D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$142
D0385	Maxillofacial MRI Image Capture D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$172
D0386	Maxillofacial Ultrasound Image Capture D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$172
D0387	Intraoral - Complete Series of Radiographic Images Limited to 1 time per consecutive 5 years. Vertical bitewings cannot be billed in conjunction with a complete series.	\$0
D0388	Bitewings - Four Radiograph Images Limited to 1 series of images per consecutive 12 months.	\$0
D0389	Intraoral - Periapical – First Radiographic Image	\$4
D0393	Treatment simulation using 3D image volume. D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$12
D0394	Digital subtraction of two or more images or image volumes of the same modality D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$12
D0395	Fusion of two or more 3D image volumes of one or more modalities D0364-D0395 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.	\$12

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D0415	Collection of Microorganisms for Culture and Sensitivity	\$0
D0425	Caries Susceptibility Tests	\$0
D0431	Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to Covered Persons over the age of 18 years.	\$75
D0460	Pulp Vitality Tests Limited to 1 charge per visit, regardless of how many teeth are tested.	\$0
D0470	Diagnostic Casts	\$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	\$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	\$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	\$0
D0480	Accession of Exfoliative Cytologic Smears, Microscopic Examination, Preparation and Transmission of Written Report	\$0
D0486	Accession of Transepithelial Cytologic Sample, Microscopic Examination, Preparation and Transmission of Written Report	\$0
D0502	Other Oral Pathology Procedures, by report	\$0
D0600	Non-ionizing Diagnostic Procedure Capable of Quantifying, Monitoring, and Recording Changes in Structure of Enamel, Dentin and Cementum	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D0601	Caries Risk Assessment and Documentation, with a Finding of Low Risk Limited to 1 time per consecutive 6 months.	\$0
D0602	Caries Risk Assessment and Documentation, with a Finding of Moderate Risk Limited to 1 time per consecutive 6 months.	\$0
D0603	Caries Risk Assessment and Documentation, with a Finding of High Risk Limited to 1 time per consecutive 6 months.	\$0
D0701	Panoramic Radiograph Image Limited to 1 time per consecutive 5 years.	\$50
D0702	Cephalometric Radiograph Image Limited to 1 time per consecutive 5 years.	\$162
D0703	Oral/Facial Photographic Images	\$20
D0705	Extra-Oral Posterior Dental Radiographic Image	\$0
D0706	Intraoral - Occlusal Radiographic Image	\$0
D0707	Intraoral - Periapical – First Radiographic Image	\$2
D0708	Bitewing – Single Radiograph Image Limited to 4 images per consecutive 12 months.	\$0
D0709	Intraoral - Complete Series of Radiographic Images Limited to 1 time per consecutive 5 years. Vertical bitewings cannot be billed in conjunction with a complete series.	\$0
D0801	3D Intraoral Surface Scan – Direct A Surface Scan of any aspect of the Intraoral Anatomy.	\$12

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D0802	3D Dental Surface Scan – Indirect A Surface Scan of a Diagnostic Cast.	\$12
D0803	3D Facial Surface Scan – Direct	\$12
D0804	3D Facial Surface Scan – Indirect A surface scan of constructed facial features.	\$12
PREVENTIVE SERVICES		
D1110	Prophylaxis – Adult Limited to 1 time per consecutive 6 months. Any additional procedures will follow D1110, Each Additional Prophylaxis, Member Co-payment.	\$0
D1110	Prophylaxis – Adult - Each Additional Prophylaxis within 6 Months Based on the Necessity Recommended by the Dentist.	\$20
D1120	Prophylaxis – Child Limited to 1 time per consecutive 6 months. Any additional procedures will follow D1120, Each Additional Prophylaxis, Member Co-payment.	\$0
D1120	Prophylaxis – Child - Each Additional Prophylaxis within 6 Months Based on the Necessity Recommended by the Dentist.	\$20
D1206	Topical Application of Fluoride Varnish Limited to Covered Persons under the age of 16 years, and limited to 1 time per consecutive 12 months.	\$20
D1208	Topical Application of Fluoride- Excluding Varnish Limited to Covered Persons under the age of 16 years, and limited to 1 time per consecutive 12 months.	\$0
D1301	Immunization counseling	\$0
D1310	Nutritional Counseling for Control of Dental Disease	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D1320	Tobacco Counseling for Control and Prevention of Dental Disease	\$0
D1330	Oral Hygiene Instructions	\$0
D1351	Sealant - Per Tooth Sealants (D1351 or D1352) are limited to one 1 time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.	\$0
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient – Permanent Tooth Sealants (D1351 or D1352) are limited to one 1 time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.	\$0
D1353	Sealant Repair – Per Tooth Limited to Covered Persons under the age of 16 years every consecutive 3 years.	\$0
D1354	Interim Caries Arresting Medicament Application -Per Tooth	\$20
D1355	Caries Preventive Medicament Application – per tooth Limited to 1 time per tooth per consecutive 6 months.	\$20
D1510	Space Maintainer - Fixed - Unilateral Limited to Covered Persons under the age of 16 years. Benefit includes all adjustment within 6 months of installation.	\$0
D1516	Space Maintainer – Fixed – Bilateral, Maxillary Limited to Covered Persons under the age of 16 years. Benefit includes all adjustment within 6 months of installation.	\$0
D1517	Space Maintainer – Fixed – Bilateral, Mandibular Limited to Covered Persons under the age of 16 years. Benefit includes all adjustment within 6 months of installation.	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D1520	Space Maintainer - Removable - Unilateral Limited to Covered Persons under the age of 16 years. Benefit includes all adjustment within 6 months of installation.	\$0
D1526	Space Maintainer – Removable – Bilateral, Maxillary Limited to Covered Persons under the age of 16 years. Benefit includes all adjustments within 6 months of installation.	\$0
D1527	Space Maintainer – Removable – Bilateral, Mandibular Limited to Covered Persons under the age of 16 years. Benefit includes all adjustments within 6 months of installation.	\$0
D1551	Re-cementation of Bilateral Space Maintainer – maxillary	\$22
D1552	Re-cementation of Bilateral Space Maintainer – mandibular	\$22
D1553	Re-cementation of Unilateral Space Maintainer – per quadrant	\$22
D1556	Removal of Fixed Unilateral Space Maintainer - Per Quadrant	\$22
D1557	Removal of Fixed Bilateral Space Maintainer – Maxillary	\$22
D1558	Removal of Fixed Bilateral Space Maintainer – Mandibular	\$22
D1575	Distal Shoe Space Maintainer – Fixed – Unilateral Limited to Covered Persons under the age of 16 years, once per 60 months. Benefit includes all adjustment within 6 months of installation.	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
RESTORATIVE SERVICES		
D2140	Amalgam - One Surface, Primary or Permanent Multiple restorations on one surface will be treated as a single filling.	\$16
D2150	Amalgam - Two Surfaces, Primary or Permanent Multiple restorations on one surface will be treated as a single filling.	\$22
D2160	Amalgam - Three Surfaces, Primary or Permanent Multiple restorations on one surface will be treated as a single filling.	\$26
D2161	Amalgam - Four or More Surfaces, Primary or Permanent Multiple restorations on one surface will be treated as a single filling.	\$30
D2330	Resin-Based Composite - One Surface, Anterior Multiple restorations on one surface will be treated as a single filling.	\$37
D2331	Resin-Based Composite - Two Surfaces, Anterior Multiple restorations on one surface will be treated as a single filling.	\$47
D2332	Resin-Based Composite - Three Surfaces, Anterior Multiple restorations on one surface will be treated as a single filling.	\$65
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior) Multiple restorations on one surface will be treated as a single filling.	\$87
D2391	Resin-Based Composite - One Surface, Posterior Multiple restorations on one surface will be treated as a single filling.	\$72
D2392	Resin-Based Composite - Two Surfaces, Posterior Multiple restorations on one surface will be treated as a single filling.	\$82

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D2393	Resin-Based Composite - Three Surfaces, Posterior Multiple restorations on one surface will be treated as a single filling.	\$97
D2394	Resin-Based Composite - Four or More Surfaces, Posterior Multiple restorations on one surface will be treated as a single filling.	\$122
D2410	Gold Foil - One Surface Multiple restorations on one surface will be treated as a single filling.	\$75
D2420	Gold Foil - Two Surfaces Multiple restorations on one surface will be treated as a single filling.	\$95
D2430	Gold Foil - Three Surfaces Multiple restorations on one surface will be treated as a single filling.	\$125
CROWNS/INLAYS/ONLAYS When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of \$30.00 per unit.		
D2390	Resin-Based Composite Crown, Anterior Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$130
D2510	Inlay - Metallic - One Surface Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$285
D2520	Inlay - Metallic - Two Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$285

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D2530	Inlay - Metallic - Three or More Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$285
D2542	Onlay - Metallic - Two Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$325
D2543	Onlay – Metallic - Three Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$340
D2544	Onlay – Metallic - Four or More Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$350
D2610	Inlay - Porcelain/Ceramic – One Surface Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$275*
D2620	Inlay - Porcelain/Ceramic - Two Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$300 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D2630	Inlay - Porcelain/Ceramic - Three or More Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$325 *
D2642	Onlay - Porcelain/Ceramic - Two Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$360 *
D2643	Onlay - Porcelain/Ceramic - Three Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$390 *
D2644	Onlay - Porcelain/Ceramic - Four or More Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$400 *
D2650	Inlay - Composite/Resin - One Surface Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$237
D2651	Inlay - Composite/Resin - Two Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$250

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D2652	Inlay - Composite/Resin - Three Or More Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$275
D2662	Onlay - Composite/Resin - Two Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$247
D2663	Onlay - Composite/Resin - Three Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$267
D2664	Onlay - Composite/Resin - Four Or More Surfaces Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$287
D2710	Crown - Resin-Based Composite (indirect) Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$195
D2712	Crown - 3/4 Resin-Based Composite (indirect) Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$195

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D2720	Crown - Resin With High Noble Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2721	Crown - Resin With Predominantly Base Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2722	Crown - Resin With Noble Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2740	Crown - Porcelain/Ceramic Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2750	Crown - Porcelain Fused To High Noble Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2751	Crown - Porcelain Fused To Predominantly Base Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D2752	Crown - Porcelain Fused To Noble Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2753	Crown – Porcelain Fused to Titanium and Titanium Alloys Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2780	Crown - 3/4 Cast High Noble Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2781	Crown - 3/4 Cast Predominately Base Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2782	Crown - 3/4 Cast Noble Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2783	Crown - 3/4 Porcelain/Ceramic Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D2790	Crown - Full Cast High Noble Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2791	Crown - Full Cast Predominantly Base Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2792	Crown - Full Cast Noble Metal Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2794	Crown – titanium Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D2799	Provisional Crown – Further Treatment of Completion of Diagnosis Necessary Prior to Final Impression Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$125
D2910	Re-cement or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration Limited to those performed more than 12 months after the initial insertion.	\$15
D2915	Re-cement Cast Or Re-Bond Cast Indirectly Fabricated or Prefabricated Post and Core Limited to those performed more than 12 months after the initial insertion.	\$20

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D2920	Re-cement or Re-Bond Crown Limited to those performed more than 12 months after the initial insertion.	\$27
D2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp Limited to those performed more than 12 months after the initial insertion.	\$27
D2928	Prefabricated Porcelain/Ceramic Crown – Permanent Tooth Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth.	\$54 *
D2929	Prefabricated Porcelain/Ceramic Crown-Primary Tooth Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth.	\$54 *
D2930	Prefabricated Stainless Steel Crown - Primary Tooth Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	\$52
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	\$85
D2932	Prefabricated Resin Crown Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth.	\$95
D2933	Prefabricated Stainless Steel Crown With Resin Window Limited to 1 time per tooth per consecutive 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	\$145

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D2940	Protective Restoration Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.	\$22
D2949	Restorative Foundation for an Indirect Restoration	\$20
D2950	Core Buildup, Including Any Pins When Required Limited to teeth that have had root canal therapy.	\$77
D2951	Pin Retention - Per Tooth, in addition to Restoration Cast Restoration is defined as Inlays and Onlays.	\$22
D2952	Post and Core in addition to Crown, Indirectly Fabricated Limited to teeth that have had root canal therapy.	\$97
D2953	Each Additional Indirectly Fabricated Post, Same Tooth Limited to teeth that have had root canal therapy.	\$95
D2954	Prefabricated Post and Core in addition to Crown Limited to teeth that have had root canal therapy.	\$97
D2955	Post Removal Limited to teeth that have had root canal therapy.	\$37
D2957	Each Additional Prefabricated Post, Same Tooth Limited to teeth that have had root canal therapy.	\$30
D2960	Labial Veneer (Resin Laminate) – Chairside Covered only when a filling cannot restore the tooth.	\$200
D2961	Labial Veneer (Resin laminate) - Laboratory Covered only when a filling cannot restore the tooth.	\$255 *
D2962	Labial Veneer (Porcelain Laminate) - Laboratory Covered only when a filling cannot restore the tooth.	\$390 *
D2971	Additional Procedures to Construct New Crown under Existing Partial Denture Framework	\$45

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D2975	Coping Not covered if done at the same time as a crown on same tooth.	\$95
D2980	Crown Repair Necessitated by Restorative Material Failure Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$95
D2981	Inlay Repair Necessitated by Restorative Material Failure Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$95
D2982	Onlay Repair Necessitated by Restorative Material Failure Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$95
D2983	Veneer Repair Necessitated by Restorative Material Failure Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$95
D2989	Excavation of a Tooth Resulting in the Determination of Non-restorability	\$125
D2990	Resin Infiltration of Incipient Smooth Surface Lesions Limited to once per first or second permanent molar every consecutive 3 years.	\$29
D2991	Application of Hydroxyapatite Regeneration Medicament – per Tooth Limited to 1 time per tooth per consecutive 3 years.	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
ENDODONTICS		
D3110	Pulp Cap - Direct (excluding final restoration) Not covered if utilized solely as a liner or base underneath a restoration.	\$32
D3120	Pulp Cap - Indirect (excluding final Restoration) Not covered if utilized solely as a liner or base underneath a restoration.	\$32
D3220	Therapeutic Pulpotomy (excluding final restoration – Removal of Pulp Coronal to the Detionocemental Junction and Application of Medicament) Limited to 1 time per primary or secondary tooth per lifetime.	\$45
D3221	Pulpal Debridement, Primary and Permanent Teeth Not covered on same day as other Endodontic services. Limit 1 per tooth per lifetime.	\$95
D3222	Partial Pulpotomy for Apexogenesis - Permanent Tooth with Incomplete Root Development Limited to 1 time per primary or secondary tooth per lifetime.	\$75
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (excluding final restoration)	\$65
D3240	Pulpal Therapy (resorbable filling) - Posterior, Primary Tooth (Excluding Final restoration)	\$57
D3310	Root Canal Therapy - Anterior (Excluding Final Restoration) Limited to 1 time per tooth per lifetime. Dentist cannot charge retreatment codes on tooth treated for the first 12 months.	\$240
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	\$250
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	\$350

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D3331	Treatment of Root Canal Obstruction, Non-Surgical Access	\$85
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth	\$75
D3333	Internal Root Repair of Perforation Defects	\$125
D3346	Retreatment of Previous Root Canal Therapy - Anterior Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	\$375
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	\$425
D3348	Retreatment of Previous Root Canal Therapy – Molar Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	\$500
D3351	Apexification/Recalcification - Initial Visit (Apical Closure/Calcific Repair of Perforations, Root Resorption, Etc.)	\$90
D3352	Apexification/Recalcification - Interim Medication Visit)Apical Closure/Calcific Repair of Perforations, Root Resorption, Pulp Space Disinfection, Etc.	\$90
D3353	Apexification/Recalcification - Final Visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$90
D3410	Apicoectomy - Anterior	\$235
D3421	Apicoectomy – Premolar (first root)	\$315

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D3425	Apicoectomy - Molar (first root)	\$347
D3426	Apicoectomy (Each Additional Root)	\$102
D3428	Bone Graft in Conjunction with Periradicular Surgery - Per Tooth, Single Site	\$47
D3429	Bone Graft in Conjunction with Periradicular Surgery - Each Additional Contiguous Tooth in the Same Surgical Site	\$42
D3430	Retrograde Filling - Per Root	\$82
D3431	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration in Conjunction with Periradicular Surgery	\$150
D3432	Guided Tissue Regeneration, Resorbable Barrier, Per Site, in Conjunction with Periradicular Surgery	\$150
D3450	Root Amputation - Per Root	\$170
D3460	Endodontic Endosseous Implant	\$549
D3470	Intentional Reimplantation (Including Necessary Splinting)	\$175
D3471	Apicoectomy/Periradicular Surgery – Anterior	\$235
D3472	Apicoectomy/Periradicular Surgery - Bicuspid (first root)	\$315
D3473	Apicoectomy/Periradicular Surgery - Molar (first root)	\$347
D3501	Surgical Exposure of Root Surface without Apicoectomy or repair of Root Resorption – Anterior	\$235
D3502	Surgical Exposure of Root Surface without Apicoectomy or Repair of Root Resorption – Premolar	\$235

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	\$235
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	\$95
D3920	Hemisection (including any root removal), not including Root Canal Therapy	\$112
D3921	Decoronation or Submergence of an Erupted Tooth	\$105
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	\$75
PERIODONTICS		
D4210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	\$182
D4211	Gingivectomy or Gingivoplasty - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	\$119
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, Per Tooth	\$65
D4240	Gingival Flap Procedure, including Root Planing - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	\$217
D4241	Gingival Flap Procedure, Including Root Planing - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	\$207
D4245	Apically Positioned Flap	\$150
D4249	Clinical Crown Lengthening - Hard Tissue	\$245
D4260	Osseous Surgery (including Elevation of a Full Thickness Flap and Closure) - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	\$375

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D4261	Osseous Surgery (including Elevation of Full Thickness Flap and Closure) - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	\$325
D4263	Bone Replacement Graft – Retained Natural Tooth - First Site in Quadrant	\$450
D4264	Bone Replacement Graft – Retained Natural Tooth - Each Additional Site in Quadrant	\$325
D4265	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration	\$82
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	\$325
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal	\$325
D4268	Surgical Revision Procedure, Per Tooth	\$0
D4270	Pedicle Soft Tissue Graft Procedure	\$310
D4273	Autogenous Connective Tissue Graft Procedures, (Including Donor and Recipient Surgical Sites) First Tooth, Implant, or Edentulous Tooth Position in Graft	\$417
D4274	Mesial/Distal or Proximal Wedge Procedure, Single Tooth (When not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area)	\$132
D4275	Non-Autogenous Connective Tissue Graft (including Recipient Site and Donor Material) First Tooth, Implant, or Edentulous Tooth Position in Graft	\$502
D4276	Combined Connective Tissue and Double Pedicle Graft, Per Tooth	\$65
D4277	Free Soft Tissue Graft Procedure (Recipient and Donor Surgical Sites), First Tooth, Implant, or Edentulous Tooth Position in Graft	\$215

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D4278	Free Soft Tissue Graft Procedure (Including Recipient and Donor Surgery Sites), Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site	\$75
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	\$372
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	\$392
D4286	Guided Tissue Regeneration - Natural Teeth - Non-resorbable Barrier, Per Site (Includes Membrane Removal	\$20
D4322	Provisional Splinting - Intracoronal Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed bridges. Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	\$115
D4323	Provisional Splinting – Extracoronal Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed bridges. Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	\$105
D4341	Periodontal Scaling and Root Planing - Four or More Teeth Per Quadrant	\$80 +
D4342	Periodontal Scaling and Root Planing - One - Three Teeth Per Quadrant	\$55 +

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D4346	Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation – Gull Mouth, After Oral Evaluation Limited to 1 time per quadrant per consecutive 6 months.	\$65
D4355	Full Mouth Debridement to Enable a Comprehensive Oral Evaluation and Diagnosis on a Subsequent Visit	\$65 +
D4381	Localized Delivery of Antimicrobial Agents via controlled release vehicle into diseased crevicular tissue, per tooth Limited to 3 sites per quadrant or 12 sites total for refractory pockets or in conjunction with Periodontal Scaling and Root Planing	\$67 +
D4910	Periodontal Maintenance Limited to 1 time per consecutive 6 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	\$72
D4920	Unscheduled Dressing Change (by someone other than treating Dentist or their Staff)	\$25
D4921	Gingival Irrigation - Per Quadrant	\$15
D4999	Unspecified periodontal procedure, by report	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
REMOVABLE DENTURES When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of \$30.00 per unit.		
D5110	Complete Denture – Maxillary Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$502 *
D5120	Complete Denture – Mandibular Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$502 *
D5130	Immediate Denture – Maxillary Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$485 *
D5140	Immediate Denture - Mandibular Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$485 *
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$407 *
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$407 *
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$507 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$507 *
D5221	Immediate Maxillary Partial Denture – Resin Base (Including any Conventional Clasps, Rests and Teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$427 *
D5222	Immediate Mandibular Partial Denture – Resin Base (Including any Conventional Clasps, Rests and Teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$427 *
D5223	Immediate Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$527 *
D5224	Immediate Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$527 *
D5225	Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$507 *
D5226	Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$507 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D5227	Immediate Maxillary Partial Denture - Resin Base (Including any Clasps, Rests and Teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$507 *
D5228	Immediate Mandibular Partial Denture - Resin Base (Including any Clasps, Rests and Teeth) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$507 *
D5282	Removable Unilateral Partial Denture – one piece Cast Metal (including Retentive/Clasping Materials, Rests, and Teeth), Maxillary Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$260 *
D5283	Removable Unilateral Partial Denture – one piece Cast Metal (including Retentive/Clasping Materials, Rests, and Teeth), Mandibular Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$260 *
D5410	Adjust Complete Denture – Maxillary Limited to repairs or adjustments performed more than 12 months after the initial insertion. All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are at no fee to the member.	\$19
D5411	Adjust Complete Denture - Mandibular Limited to repairs or adjustments performed more than 12 months after the initial insertion. All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are at no fee to the member.	\$19

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D5421	Adjust Partial Denture – Maxillary Limited to repairs or adjustments performed more than 12 months after the initial insertion. All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are at no fee to the member.	\$19
D5422	Adjust Partial Denture – Mandibular Limited to repairs or adjustments performed more than 12 months after the initial insertion. All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are at no fee to the member.	\$19
D5511	Repair Broken Complete Denture Base, Mandibular Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$57 *
D5512	Repair Broken Complete Denture Base, Maxillary Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$57 *
D5520	Replace Missing or Broken Teeth - Complete Denture (each tooth)	\$42 *
D5611	Repair Resin Partial Denture Base, Mandibular Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$42 *
D5612	Repair Resin Partial Denture Base, Maxillary Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$42 *
D5621	Repair Cast Partial Framework, Mandibular Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$57 *
D5622	Repair Cast Partial Framework, Maxillary Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$57 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D5630	Repair or Replace Broken Clasp – Per Tooth Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$87 *
D5640	Replace Broken Teeth - Per Tooth Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$42 *
D5650	Add Tooth to Existing Partial Denture Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$72 *
D5660	Add Clasp to Existing Partial Denture – Per Tooth Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$87 *
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary) Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$205 *
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular) Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$205 *
D5710	Rebase Complete Maxillary Denture Limited to rebasing performed more than 6 months after the initial insertion.	\$187 *
D5711	Rebase Complete Mandibular Denture Limited to rebasing performed more than 6 months after the initial insertion.	\$187 *
D5720	Rebase Maxillary Partial Denture Limited to rebasing performed more than 6 months after the initial insertion.	\$162 *
D5721	Rebase Mandibular Partial Denture Limited to rebasing performed more than 6 months after the initial insertion.	\$162 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D5725	Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular) Limited to repairs or adjustments rebasing performed more than 12 months after the initial insertion.	\$162 *
D5730	Reline Complete Maxillary Denture (Chairside) Limited to relining performed more than 6 months after the initial insertion. New dentures include one (1) reline within the first six (6) months.	\$117 *
D5731	Reline Complete Mandibular Denture (Chairside) Limited to relining performed more than 6 months after the initial insertion. New dentures include one (1) reline within the first six (6) months.	\$117 *
D5740	Reline Maxillary Partial Denture (Chairside) Limited to relining performed more than 6 months after the initial insertion. New dentures include one (1) reline within the first six (6) months.	\$102 *
D5741	Reline Mandibular Partial Denture (Chairside) Limited to relining performed more than 6 months after the initial insertion. New dentures include one (1) reline within the first six (6) months.	\$102 *
D5750	Reline Complete Maxillary Denture (Laboratory) Limited to relining performed more than 6 months after the initial insertion. New dentures include one (1) reline within the first six (6) months.	\$152 *
D5751	Reline Complete Mandibular Denture Laboratory) Limited to relining performed more than 6 months after the initial insertion. New dentures include one (1) reline within the first six (6) months.	\$152 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D5760	Reline Maxillary Partial Denture (Laboratory) Limited to relining performed more than 6 months after the initial insertion. New dentures include one (1) reline within the first six (6) months.	\$152 *
D5761	Reline Mandibular Partial Denture (Laboratory) Limited to relining performed more than 6 months after the initial insertion. New dentures include one (1) reline within the first six (6) months.	\$152 *
D5765	Soft liner for complete or partial removable denture - indirect	\$69
D5810	Interim Complete Denture (Maxillary) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$250 *
D5811	Interim Complete Denture (Mandibular) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$250 *
D5820	Interim Partial Denture (Maxillary) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$167 *
D5821	Interim Partial Denture (Mandibular) Limited to 1 per consecutive 5 years. No additional allowances for precision or semi-precision attachments.	\$167 *
D5850	Tissue Conditioning, Maxillary	\$50
D5851	Tissue Conditioning, Mandibular	\$50
D5862	Precision Attachment, By Report	\$150

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D5899	Unspecified Removable Prosthodontic Procedure, By Report	\$0
D5982	Surgical Stent	\$155 *
D5987	Commissure Splint	\$155 *
D5988	Surgical Splint	\$155 *
PROSTHODONTIC SERVICES When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of \$30.00 per unit.		
D6205	Pontic - Indirect Resin Based Composite Limited to 1 time per tooth per consecutive 5 years.	\$795
D6210	Pontic - Cast High Noble Metal Limited to 1 time per tooth per consecutive 5 years.	\$290 *
D6211	Pontic - Cast Predominantly Base Metal Limited to 1 time per tooth per consecutive 5 years.	\$290 *
D6212	Pontic - Cast Noble Metal Limited to 1 time per tooth per consecutive 5 years.	\$290 *
D6214	Pontic – Titanium Limited to 1 time per tooth per consecutive 5 years.	\$290 *
D6240	Pontic - Porcelain Fused to High Noble Metal Limited to 1 time per tooth per consecutive 5 years.	\$290 *
D6241	Pontic - Porcelain Fused to Predominantly Base Metal Limited to 1 time per tooth per consecutive 5 years.	\$290 *
D6242	Pontic - Porcelain Fused to Noble Metal Limited to 1 time per tooth per consecutive 5 years.	\$290 *
D6243	Pontic - Porcelain Fused to High Noble Metal Limited to 1 time per tooth per consecutive 5 years.	\$290 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6245	Pontic - Porcelain/Ceramic Limited to 1 time per tooth per consecutive 5 years.	\$290 *
D6250	Pontic - Resin with High Noble Metal Limited to 1 time per tooth per consecutive 5 years.	\$290 *
D6251	Pontic - Resin with Predominantly Base Metal Limited to 1 time per tooth per consecutive 5 years.	\$290 *
D6252	Pontic - Resin with Noble Metal Limited to 1 time per tooth per consecutive 5 years.	\$290 *
D6253	Provisional Pontic – Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	\$0
D6545	Retainer - Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per consecutive 5 years.	\$180
D6548	Retainer - Porcelain/Ceramic for Resin Bonded Fixed Prosthesis Limited to 1 time per consecutive 5 years.	\$225 *
D6600	Retainer Inlay - Porcelain/Ceramic - Two Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6601	Retainer Inlay - Porcelain/Ceramic, Three or More Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6602	Retainer Inlay - Cast Metal, Two Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6603	Retainer Inlay - Cast High Noble Metal, Three or More Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6604	Retainer Inlay - Cast Predominantly Base Metal, Two Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6605	Retainer Inlay - Cast Predominantly Base Metal, Three or More Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6606	Retainer Inlay - Cast Noble Metal - Two Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6607	Retainer Inlay - Cast Noble Metal - Three or More Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6608	Retainer Onlay - Porcelain/Ceramic - Two Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6609	Retainer Onlay - Porcelain/Ceramic - Three or More Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6610	Retainer Onlay - Cast High Noble Metal - Two Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6611	Retainer Onlay - Cast High Noble Metal - Three or More Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6612	Retainer Onlay - Cast Predominantly Base Metal -Two Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6613	Retainer Onlay - Cast Predominantly Base Metal - Three or More Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6614	Retainer Onlay - Cast Noble Metal - Two Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6615	Retainer Onlay - Cast Noble Metal - Three or More Surfaces Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6624	Retainer Inlay – Titanium Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6634	Retainer Onlay – Titanium Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6710	Retainer Crown - Indirect Resin Based Composite (not to be used as a temporary or provisional prosthesis) Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6720	Retainer Crown - Resin with High Noble Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6721	Retainer Crown - Resin with Predominantly Base Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6722	Retainer Crown - Resin with Noble Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6740	Retainer Crown - Porcelain/Ceramic Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6750	Retainer Crown - Porcelain Fused to High Noble Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6751	Retainer Crown - Porcelain Fused to Predominantly Base Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6752	Retainer Crown - Porcelain Fused to Noble Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6753	Retainer Crown - Porcelain Fused to High Noble Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6780	Retainer Crown - 3/4 Cast High Noble Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6781	Retainer Crown - 3/4 Cast Predominately Based Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6782	Retainer Crown - 3/4 Cast Noble Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6783	Retainer Crown - 3/4 Porcelain/Ceramic Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6784	Retainer Crown - 3/4 Cast High Noble Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6790	Retainer Crown - Full Cast High Noble Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6791	Retainer Crown - Full Cast Predominantly Base Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6792	Retainer Crown - Full Cast Noble Metal Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6793	Provisional Retainer Crown – Further Treatment of Completion of Diagnosis Necessary Prior to Final Impression Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$125

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6794	Retainer Crown – Titanium Limited to 1 time per consecutive 5 years. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	\$290 *
D6930	Re-cement or Re-Bond Fixed Partial Denture Limited to those performed more than 12 months after the initial insertion.	\$30
D6940	Stress Breaker	\$125
D6950	Precision Attachment	\$195
D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$80
ORAL SURGERY		
D7111	Extraction, Coronal Remnants – Primary Tooth	\$65
D7140	Extraction, Erupted Tooth or Exposed Root (elevation and/or forceps removal)	\$35
D7210	Surgical Removal of Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth and Including Elevation of Mucoperiosteal Flap if Indicated	\$105
D7220	Removal of Impacted Tooth - Soft Tissue Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general Dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the Dentist's usual and customary fees.	\$102

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D7230	Removal of Impacted Tooth - Partially Bony Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general Dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the Dentist's usual and customary fees.	\$107
D7240	Removal of Impacted Tooth - Completely Bony Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the Dentist's usual and customary fees.	\$162
D7241	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general Dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the Dentist's usual and customary fees.	\$157
D7250	Surgical Removal of Residual Tooth Roots (cutting procedure) Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general Dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the Dentist's usual and customary fees.	\$40

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D7251	Coronectomy – Intentional Partial Tooth Removal	\$270
D7260	Oroantral Fistula Closure	\$160
D7261	Primary Closure of a Sinus Perforation	\$275
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	\$95
D7272	Tooth Transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	\$100
D7280	Surgical Access of an Unerupted Tooth	\$125
D7282	Mobilization of Erupted or Malpositioned Tooth to aid Eruption	\$125
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	\$80
D7285	Incisional Biopsy of Oral Tissue - Hard (bone, tooth) Limited to 1 biopsy per site per visit.	\$155
D7286	Incisional Biopsy of Oral Tissue - Soft (all others) Limited to 1 biopsy per site per visit.	\$100
D7287	Exfoliative Cytological Sample Collection	\$85
D7288	Brush Biopsy - Transepithelial Sample Collection	\$25
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report	\$40
D7310	Alveoloplasty In Conjunction With Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant	\$40

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D7311	Alveoplasty In Conjunction With Extraction - One to Three Teeth or Tooth Spaces, Per Quadrant	\$40
D7320	Alveoloplasty Not In Conjunction With Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant	\$157
D7321	Alveoplasty Not In Conjunction With Extraction - One to Three Teeth or Tooth Spaces, Per Quadrant	\$157
D7340	Vestibuloplasty - Ridge Extension (secondary epithelialization)	\$370
D7350	Vestibuloplasty - Ridge Extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$990
D7410	Excision of Benign Lesion up to 1.25 Cm Limited to 1 per site per visit.	\$25
D7411	Excision of Benign Lesion greater than 1.25 cm Limited to 1 per site per visit.	\$50
D7412	Excision of Benign Lesion – Complicated Limited to 1 per site per visit.	\$55
D7450	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter up to 1.25 cm Limited to 1 per site per visit.	\$65
D7471	Removal of Lateral Exostosis (Maxilla or Mandible) Limited to 1 per site per visit.	\$95
D7472	Removal of Torus Palatinus Limited to 1 per site per visit.	\$65
D7473	Removal of Torus Mandibularis Limited to 1 per site per visit.	\$95
D7485	Surgical Reduction of Osseous Tuberosity Limited to 1 per site per visit.	\$95

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D7509	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter up to 1.25 cm Limited to 1 per site per visit.	\$65
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue Limited to 1 per site per visit.	\$20
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue - Complicated (includes drainage of multiple fascial spaces) Limited to 1 per site per visit.	\$20
D7520	Incision and Drainage of Abscess - Extraoral Soft Tissue Limited to 1 per site per visit.	\$20
D7521	Incision and Drainage of Abscess - Extraoral Soft Tissue - Complicated (Includes Drainage of Multiple Fascial Spaces) Limited to 1 per site per visit.	\$20
D7910	Suture of Recent Small Wounds up to 5 cm	\$35
D7921	Collection and Application of Autologous Blood Concentrate Product	\$125
D7950	Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Maxilla - AutoGenous or Nonautogenous, by Report	\$350
D7951	Sinus Augmentation with Bone or Bone Substitutes Via a Lateral Open Approach	\$800
D7952	Sinus Augmentation Via a Vertical Approach	\$350
D7956	Guided Tissue Regeneration - Natural Teeth - Resorbable Barrier, Per Site	\$325
D7957	Guided Tissue Regeneration - Natural Teeth - Non-resorbable Barrier, Per Site (Includes Membrane Removal)	\$325

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D7961	Frenulectomy (buccal/labial) – Also Known As Frenectomy or Frenotomy - Separate Procedures Not Incidental to Another Procedure	\$112
D7962	Frenulectomy (lingual) – Also Known As Frenectomy or Frenotomy - Separate Procedures Not Incidental to Another Procedure	\$112
D7963	Frenuloplasty	\$112
D7970	Excision of Hyperplastic Tissue - Per Arch	\$140
D7971	Excision of Pericoronal Gingival	\$102
D7972	Surgical Reduction of Fibrous Tuberosity	\$125
ADJUNCTIVE SERVICES		
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure Covered as a separate benefit only if no other services, other than the exam and radiographs, were done on the same tooth during the visit. Emergency treatment is available for palliative treatment for the abatement of pain up to \$100 per occurrence.	\$0
D9120	Fixed Partial Denture Sectioning	\$0
D9210	Local Anesthesia not in conjunction with Operative or Surgical Procedures	\$0
D9211	Regional Block Anesthesia	\$0
D9212	Trigeminal Division Block Anesthesia	\$0
D9215	Local Anesthesia In Conjunction with Operative or Surgical Procedures	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D9222	Deep Sedation/General Anesthesia – First 15 Minutes Covered for patients if it is medically Necessary and approved..	\$50
D9223	Deep Sedation/General Anesthesia – Each Subsequent 15 Minute Increment Covered for patients if it is medically Necessary and approved..	\$50
D9230	Inhalation of Nitrous Oxide/Anxiolysis, Analgesia Covered when Necessary in conjunction with Covered Dental Care Services.	\$20
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia- First 15 Minutes Covered when Necessary in conjunction with Covered Dental Care Services.	\$65
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia – Each Subsequent 15 Minute Increment Covered when Necessary in conjunction with Covered Dental Care Services.	\$65
D9248	Non-Intravenous Moderate (Conscious) Sedation Covered when Necessary in conjunction with Covered Dental Care Services.	\$15
D9310	Consultation (diagnostic service provided by Dentist or Physician other than practitioner providing treatment) Not covered if done with exams or professional visit.	\$25
D9430	Office Visit – Observation (during office hours	\$5
D9440	Office Visit – after regularly scheduled hours	\$35
D9450	Case Presentation, Detailed and Extensive Treatment Planning	\$0
D9610	Therapeutic Parenteral Drug Single Administration	\$15

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D9612	Therapeutic Parenteral Drugs, Two or More Administrations, Different Medications	\$0
D9630	Drugs and/or Medicaments Dispensed in the Office for Home Use	\$15
D9910	Application of Desensitizing Medicament	\$20
D9912	Pre-visit Patient Screening	\$0
D9930	Treatment of Complications (post-surgical) - Unusual Circumstances, by report	\$0
D9932	Cleaning and Inspection of Removable Complete Denture, Maxillary	\$0
D9933	Cleaning and Inspection of Removable Complete Denture, Mandibular	\$0
D9934	Cleaning and Inspection of Removable Partial Denture, Maxillary	\$0
D9935	Cleaning and Inspection of Removable Partial Denture, Mandibular	\$0
D9942	Repair and/or Reline of Occlusal Guards	\$40
D9943	Occlusal Guard Adjustment	\$25
D9944	Occlusal Guard – Hard Appliance, Full Arch Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.	\$250
D9945	Occlusal Guard – Soft Appliance, Full Arch Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.	\$250
D9946	Occlusal Guard – Hard Appliance, Partial Arch Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.	\$250

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D9947	Custom Sleep Apnea Appliance Fabrication and Placement Limited to 1 time every consecutive 36 months.	\$1,900
D9948	Adjustment of Custom Sleep Apnea Appliance	\$85
D9949	Repair of Custom Sleep Apnea Appliance	\$88
D9950	Occlusion Analysis - Mounted Case	\$75
D9951	Occlusal Adjustment - Limited	\$30
D9952	Occlusal Adjustment – Complete	\$137
D9953	Reline Custom Sleep Apnea Appliance (Indirect)	\$117
D9973	External Bleaching – Per Tooth	\$30
D9975	External Bleaching for Home Application, Per Arch; Includes Materials and Fabrication of Custom Trays	\$240
D9986	Missed Appointment	\$25
D9991	Dental Case Management – Addressing Appointment Compliance Barriers	\$0
D9992	Dental case management – care coordination	\$0
D9993	Dental case management – motivational interviewing	\$0
D9994	Dental case management – patient education to improve oral health literacy	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D9995	Teledentistry – Synchronous Real-time Encounter Limited to 2 times per Plan Year.	\$0
D9996	Teledentistry – Asynchronous information Stored and Forwarded to Dentist for Subsequent Review Limited to 2 times per Plan Year.	\$0
IMPLANT PROCEDURES When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of \$30.00 per unit.		
D6010	Surgical Placement of Implant Body: Endosteal Implant Limited to 1 time per implant site per consecutive 5 years.	\$1,050
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis: Endosteal Implant Limited to 1 time per implant site per consecutive 5 years.	\$1,050
D6056	Prefabricated Abutment - Includes Modification and Placement Limited to 1 time per tooth per consecutive 5 years.	\$475
D6057	Custom Fabricated Abutment - Includes Placement Limited to 1 time per tooth per consecutive 5 years.	\$595
D6058	Abutment Supported Porcelain/Ceramic Crown Limited to 1 time per tooth per consecutive 5 years.	\$795
D6059	Abutment Supported Porcelain Fused to Metal Crown (high noble metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6060	Abutment Supported Porcelain Fused to Metal Crown (predominately base metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6062	Abutment Supported Cast Metal Crown (High Noble Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6063	Abutment Supported Cast Metal Crown (predominately base metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6064	Abutment Supported Cast Metal Crown (noble metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6065	Implant Supported Porcelain/Ceramic Crown Limited to 1 time per tooth per consecutive 5 years.	\$795
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, High Noble Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy, High Noble Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD Limited to 1 time per tooth per consecutive 5 years.	\$795
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominately Base Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominately Base Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6075	Implant Supported Retainer for Ceramic FPD Limited to 1 time per tooth per consecutive 5 years.	\$795
D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy, High Noble Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy, High Noble Metal) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6080	Implant Maintenance Procedures, When Prostheses are Removed and Reinstated, Including Cleansing of Prostheses and Abutments.	\$180
D6081	Scaling and Debridement in the Presence of Inflammation or Mucositis of a Single Implant, Including Cleaning of the Implant Surfaces, Without Flap Entry and Closure	\$80 +
D6082	Implant Supported Porcelain Fused to Metal Crown Limited to 1 time per tooth per consecutive 5 years.	\$795
D6083	Implant Supported Porcelain Fused to Noble Metal Crown Limited to 1 time per tooth per consecutive 5 years.	\$795
D6084	Implant Supported Porcelain Fused to High Noble Metal Crown Limited to 1 time per tooth per consecutive 5 years.	\$795
D6085	Provisional Implant Crown Limited to 1 time per tooth per consecutive 5 years.	\$125
D6086	Implant Supported Metal Crown Limited to 1 time per tooth per consecutive 5 years.	\$795

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6087	Implant Supported Noble Metal Crown Limited to 1 time per tooth per consecutive 5 years.	\$795
D6088	Implant Supported High Noble Metal Crown Limited to 1 time per tooth per consecutive 5 years.	\$795
D6089	Accessing and Retorquing Loose Implant Screw - per Screw Limited to those performed more than 12 months after the initial insertion.	\$50
D6090	Repair Implant Supported Prosthesis, by report Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$400
D6092	Re-cement Implant/Abutment Supported Crown Limited to those performed more than 12 months after the initial insertion.	\$45
D6093	Re-cement Implant/Abutment Supported Fixed Partial Denture Limited to those performed more than 12 months after the initial insertion.	\$65
D6094	Abutment Supported Crown - (Titanium) Limited to 1 time per tooth per consecutive 5 years.	\$795
D6096	Remove Broken Implant Retaining Screw Limited to repairs or adjustments performed more than 12 months after the initial insertion.	\$500
D6097	Abutment Supported Crown - Porcelain Fused to Titanium and Titanium Alloys Limited to 1 time per tooth per consecutive 5 years.	\$795
D6098	Implant Supported Retainer for Porcelain Fused to Metal Limited to 1 time per consecutive 5 years.	\$795
D6099	Implant Supported Retainer for Porcelain Fused to Noble Metal FPD Limited to 1 time per consecutive 5 years.	\$795

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6100	Implant Removal, by Report	\$700
D6105	Removal of implant body not requiring bone removal nor flap elevation	\$700
D6106	Guided Tissue Regeneration - Natural Teeth - Resorbable Barrier, Per Site	\$325
D6107	Guided Tissue Regeneration - Natural Teeth - Non-resorbable Barrier, Per Site (Includes Membrane Removal)	\$325
D6110	Implant /Abutment Supported Removable Denture for Edentulous Arch – Maxillary Limited to 1 per quadrant or site per consecutive 5 years.	\$1,300
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular Limited to 1 per quadrant or site per consecutive 5 years.	\$1,300
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary Limited to 1 per quadrant or site per consecutive 5 years.	\$1,040
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular Limited to 1 per quadrant or site per consecutive 5 years.	\$1,040
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary Limited to 1 per quadrant or site per consecutive 5 years.	\$3,900
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular Limited to 1 per quadrant or site per consecutive 5 years.	\$3,900

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary Limited to 1 per quadrant or site per consecutive 5 years.	\$2,300
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular Limited to 1 per quadrant or site per consecutive 5 years.	\$2,300
D6118	Implant/Abutment Supported Interim Fixed Denture for Edentulous arch – Mandibular Limited to 1 time per implant site per consecutive 5 years.	\$1,840
D6119	Implant/Abutment Supported Interim Fixed Denture for Edentulous Arch – Maxillary Limited to 1 time per implant site per consecutive 5 years.	\$1,840
D6120	Implant Supported Retainer for Porcelain Fused to High Noble Metal Limited to 1 time per per consecutive 5 years.	\$795
D6121	Implant Supported Retainer for Cast Metal FPD Limited to 1 time per per consecutive 5 years.	\$795
D6122	Implant Supported Retainer for Noble Metal FPD Limited to 1 time per per consecutive 5 years.	\$795
D6123	Implant Supported Retainer for High Noble Metal FPD Limited to 1 time per per consecutive 5 years.	\$795
D6190	Radiographic/Surgical Implant Index, by report	\$235
D6193	Replacement of an Implant Screw Limited to those performed more than 12 months after the initial insertion.	\$595
D6198	Remove Interim Implant Component	\$700

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
TMD (commonly known as TMJ) Services related to Temporomandibular Joint/Temporomandibular Disorder.		
D0320	Temporomandibular Joint Arthrogram, Including Injection	\$250
D0321	Other Temporomandibular Joint Radiograph Images	\$150
D0322	Tomographic Survey	\$150
ORTHODONTICS		
Orthodontic services are subject to payment of any applicable Co-payments. Benefits will be paid in equal monthly installments on a schedule determined by the Policyholder over the course of the orthodontic treatment plan performed during a 24 month period, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Benefits end when the 24 month orthodontic treatment ends.		
D8010	Limited Orthodontic Treatment of the Primary Dentition	\$1,375
D8020	Limited Orthodontic Treatment of the Transitional Dentition Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.	\$1,375
D8030	Limited Orthodontic Treatment of the Adolescent Dentition Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.	\$1,375
D8040	Limited Orthodontic Treatment of the Adult Dentition Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.	\$1,800

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.	\$2,650
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.	\$2,775
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.	\$2,875
D8210	Removable Appliance Therapy Harmful habit appliances are limited to one (1) time per person under the age of 16.	\$103
D8220	Fixed Appliance Therapy Harmful habit appliances are limited to one (1) time per person under the age of 16.	\$103
D8660	Pre-Orthodontic Treatment Visit	\$35
D8670	Periodic Orthodontic Treatment Visit (as Part of Contract)	\$0
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	\$300
D8681	Removable Orthodontic Retainer Adjustment	\$0
D8698	Recement/Rebond Fixed Retainers-Maxillary	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK CO-PAYMENT is shown as a fixed dollar amount.
D8699	Recement/Rebond Fixed Retainers-Mandibular	\$0
D8999	Start-up Fee (Including Exam, Beginning Records, X-rays, Tracing, Photos and Models)	\$250

Co-payments marked by “*” do not include the cost of material and laboratory fees. Additional cost to patient is as follows:

- High noble metal (precious) up to \$145.00
- Titanium metal up to \$120 (covered with proof of allergy to other metals)
- Noble metal (semi-precious) up to \$120.00
- Predominantly base metal (non-precious) up to \$55.00
- Crown laboratory fees up to \$155.00
- Laboratory fees on dentures up to \$225.00
- Porcelain laboratory fees for D2610-D2644, D2929, D2961, D2962, D6600, D6601, D6608, and D6609 up to \$65.00
- Denture repair laboratory fees up to \$50.00
- All ceramic and/or porcelain crown material fees up to \$155.00

Copies of X-rays can be obtained for \$2 per periapical image up to a maximum of \$30. Panoramic X-ray can be obtained for a \$15 fee.

Co-payments marked by a “+” are not eligible at a specialist.

The following exclusions apply to this plan.

Exclusion:

1. Services not listed on the Schedule of Covered Dental Care Services are charged to you or the Covered Person, at a 25% discount of the Network's Dental Providers Usual and Customary Fee.
2. Services provided by an out-of-Network General Dental Provider or out-of-Network Specialty Dental Provider without prior approval, except emergencies.

All Dental Care Services and procedures follow the criteria specified in the Current Dental Terminology (CDT) listing as defined by the American Dental Association.