Filing at a Glance

Company: Ameritas Life Insurance Corp.

Product Name: National Association of Realtors	SERFF Tr Num: AMFA-126826843	State: Arkansas
TOI: H10G Group Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 46900
Sub-TOI: H10G.000 Health - Dental	Co Tr Num: NATIONAL ASSOCIATION OF REALTORS	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Janis Landon	Disposition Date: 10/07/2010
	Date Submitted: 09/24/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: National Association of Realtors
Project Number: National Association of Realtors
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/07/2010

Deemer Date:
Submitted By: Janis Landon

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Group Market Type: Association
Explanation for Other Group Market Type:
State Status Changed: 10/07/2010
Created By: Janis Landon
Corresponding Filing Tracking Number: AMFA-126386513

Filing Description:

RE: Request for Review - Eligibility of a Group under §23-86-106(2)(A)
National Association of Realtors

Dear Sir/Madam:

Enclosed for your review and approval is the above captioned out-of-state group. Ameritas Life Insurance Corp. (“Ameritas”) is an Arkansas licensed insurer and has recently issued a group policy providing dental benefits to the

members of the National Association of Realtors (NAR).

NAR requested some changes to be made to their original policy and certificates. We have made these changes we could within the variability of the filing. This association was originally approved by your department on January 15, 2010 under SERFF Tracking Number: AMFA-126386513. All the required documents were provided under this filing. The new plan effective date is July 1, 2010. We have provided both the red-line version and the final print version of the policy for your review. Per email from Ms. Rosalind Minor on September 14, 2010, we were advised we only need to provide these two documents.

Thank you for your review of this filing. If you need anything additional, please feel free to contact me at 800-745-1112, ext. 82444, FAX 402-309-2573 or email jlandon@ameritas.com.

Sincerely,

Janis Landon
Senior Contract Analyst

Company and Contact

Filing Contact Information

Janis Landon, Senior Contract Analyst	jlandon@ameritas.com
475 Fallbrook Blvd.	800-745-1112 [Phone] 82444 [Ext]
Lincoln, NE 68521	402-309-2573 [FAX]

Filing Company Information

Ameritas Life Insurance Corp.	CoCode: 61301	State of Domicile: Nebraska
5900 O Street	Group Code: 943	Company Type:
P O Box 81889	Group Name:	State ID Number:
Lincoln, NE 68501-1889	FEIN Number: 47-0098400	
(800) 756-1112 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	

SERFF Tracking Number:	*AMFA-126826843*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*46900*
Company Tracking Number:	*NATIONAL ASSOCIATION OF REALTORS*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*National Association of Realtors*		
Project Name/Number:	*National Association of Realtors/National Association of Realtors*		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ameritas Life Insurance Corp.	$50.00	09/24/2010	39885225

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/07/2010	10/07/2010

Disposition

Disposition Date: 10/07/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFA-126826843*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*46900*
Company Tracking Number:	*NATIONAL ASSOCIATION OF REALTORS*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*National Association of Realtors*		
Project Name/Number:	*National Association of Realtors/National Association of Realtors*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Group Master Policy - Red-line Version	Approved-Closed	Yes
Supporting Document	Group Master Policy - Final Version	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/07/2010

Comments:

Attachment:

AR NAR Readability .pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/07/2010

Comments:

Application also provided on January 15, 2010 under SERFF Tracking Number: AMFA-126386513.

Attachment:

NAR Signed Application.pdf

		Item Status:	Status Date:
Satisfied - Item:	Group Master Policy - Red-line Version	Approved-Closed	10/07/2010

Comments:

Attachment:

010-350635EP_070110 redline.pdf

		Item Status:	Status Date:
Satisfied - Item:	Group Master Policy - Final Version	Approved-Closed	10/07/2010

Comments:

Attachment:

010-350635EP_0710 Policy.pdf

		Item Status:	Status Date:

SERFF Tracking Number:	*AMFA-126826843*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*46900*
Company Tracking Number:	*NATIONAL ASSOCIATION OF REALTORS*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*National Association of Realtors*		
Project Name/Number:	*National Association of Realtors/National Association of Realtors*		

Satisfied - Item: Cover Letter Approved-Closed 10/07/2010

Comments:

Attachment:

Cover Ltr 092410.pdf

STATE OF ARKANSAS

CERTIFICATE OF READABILITY

INSURER: Ameritas Life Insurance Corp.

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

FORM NO:	FLESCH SCORE:	FORM NAME:
9000 Policy Rev. 03-08	50, with policy/certificate	Policy Cover

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: Gail M. Garcia

Digitally signed by Gail M. Garcia
DN: cn=Gail M. Garcia, o=Ameritas Life Insurance Co, ou=Group Compliance, email=ggarcia@ameritas.com, c=US
Date: 2010.09.22 14:31:54 -05'00'

TYPED NAME: Gail M. Garcia
TITLE: Vice President - Group Compliance

DATE: 09/22/2010

NOV 20 2009

application

See reverse side for additional information.

AMERITAS LIFE INSURANCE CORP.
Lincoln, NE

for association group dental and/or vision insurance

1. Applicant's Legal Name National Association of REALTORS®

2.
60611-4087
P.O. Box / ZIP Code
430 North Michigan Ave.
Street Address
Chicago, IL 60611-4087
City / State / ZIP
Phone No. Fax No.
E-mail Address Tax I.D. No.

3. What is the type and occupational nature of the association?
(Please provide copy of association bylaws.)
XX Trade Real estate
I Professional
I Other

4. Eligibility
Total number of eligible employees 1,200,000
Employees in waiting period ..... N/A

5. Are any Association chapters, classes of members or locations excluded? ..... I Yes I XX No
Are domestic partners included? ..... I XX Yes I No
Are retirees included? ..... I XX Yes I No
(If yes, please use reverse side for explanation.)

6. Are employees of Association members or Non-Association members eligible to participate? ..... I XX Yes I No
(If yes, please use reverse side to list name and location.)

7. Who is responsible for eligibility verification?
I Association Office I Broker/TPA
X Other SASid

8. The following coverages are applied for:
Employee & Dependents Benefits
X Dental X Orthodontia X Eye Care
I Other
Employee Only Benefits
I Dental I Orthodontia I Eye Care
I Other

9. Member Participation/Contribution
XX Members pay 100% of premiums
I Premiums paid by Association dues
I Other:

10. Dependent Participation/Contribution
XX Members pay 100% of premiums
I Premiums paid by Association dues
I Other:

11. Waiting Period
_____ for those employed on or before the policy effective date.
Next Day for those employed after the new policy effective date.

12. Effective Date and Termination Date
I Immediate
I First of Month Effective date / End of Month Termination date
XX Other Next Day Coverage

13. Premium Payment Mode (In advance)
XX Monthly I Quarterly I Semi-Annual I Annual

14. If a policy effective date is other than first of the month, is a first-of-the-month premium due date desired? ..... XX Yes I No

15. Billing Options
I Home Office
XX Third-Party Administration (TPA must be approved by us.)
Shannon Kennedy, SASid
Contact Name
President
Title
462 Midland Road
Street Address
Janesville, WI 53546
City / State / ZIP
608-756-2290
Phone No. Fax No.
admin@sasid.com
E-mail Address

16. Policy and Certificate Delivery (select one)
A. eCert*/ePolicy (*generic cert, non-personalized)
XX via PDF format sent via e-mail to:
Admin@sasid.com
I via eService and member portal
B. Paper policy/personalized certificates
I Initial employees only
I Subsequently added employees
Note: eCert will be available on member portal for all members.

17. Insurance requested on this application will replace the coverage(s) checked.

Coverages: I Dental I Orthodontia I Eye Care

I Other _____

Name of Current Carrier _____

Policy No. _____

I Coverage applied for is replacing comparable coverage now or previously in force with another carrier.

I It is intended that the insurance coverage applied for be in addition to, supplemented by, or supplemental to any similar coverage now in force, or to be in force, with this or any other carrier.

Termination Date _____ Original Effective date _____

Item 5: Exclusions

a. Classes, include reason for exclusion.

Association Executives (AE) and NAR staff.

b. Locations, if location is different from applicant's, list city and state.

Plan Design and Proposed Rates: See attached Plan Summary

Additional Remarks: 2 year rate guarantee. Exclusive rates and plan designs for members of the NAR. Bonus benefits: cosmetic, orthodontia, LASIK & dental rewards.

Agreements

This application will be subject to review and approval by the Home Office of Ameritas Life Insurance Corp. If this application is accepted, the final rates and benefits will be based on verification of this information and final enrollment numbers. This applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. Any policy including riders issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Ameritas Life Insurance Corp., group insurance at the Company's rates and under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

Statements

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (See state-specific statements.) • **Note for California Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. For group policies issued, amended, delivered or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents. • **Note for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts for information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. • **Note for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. • **Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law. • **Note for Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. • **Note for New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. • **Note for New Mexico Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. • **Note for Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

☐ **If you do not want your company name used by Ameritas Life Insurance Corp. in our effort to recruit PPO providers, check this box.**

Signed at: City Chicago State IL Date 11/18/2009

Signed by: (Policyholder Representative)

Printed name and title Robert A. Goldberg Senior VP

Signature

Soliciting Agent: I understand and agree that if I'm not already appointed with Ameritas Life Insurance Corp., I must apply to and be appointed with Ameritas before I present this product to any client.

Printed Name Shannon Kennedy, SASid For FL agents only, provide FL license #

Signature

The policy provides dental and/or vision benefits only. Review your policy carefully.

Was a binder check received? ☐ Yes ☒ No If yes, then amount $ N/A.

Check received by (agent) N/A **Authorized by** (policyholder)

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AMERITAS LIFE INSURANCE CORP.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL INSURANCE POLICY

The Policyholder	**NATIONAL ASSOCIATION OF REALTORS**		
		Policy Number	**10-350635**
State of Delivery	**Illinois**	**Plan Effective Date**	**July 1, 2010**
Premium Due Date 1st of each month.		**Renewal Date**	**Jnly 1, 2012**

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

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

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

AMERITAS LIFE INSURANCE CORP.

Secretary

President

Notice of Grievance Procedures

In accordance with the Dental Care Patient Protection Act of the Illinois Insurance Code

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328 (Toll-Free)
402-309-2579 (FAX)

Please read this notice carefully. This notice contains important information about how to file grievances with your insurer. If you have questions, please feel free to contact the toll-free number shown above. Also, you always have the right to contact the Illinois Department of Insurance if you have a question or concern regarding your coverage under this contract. The Illinois Department may be contacted:

In Writing:	Illinois Department of Financial & Professional Regulation Division of Insurance Office of Consumer Health Insurance 320 West Washington Street Springfield, IL 62767-0001
By toll-free phone:	877-527-9431

I. Definitions

"Adverse Determination" means a determination by a health carrier that a health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced or terminated.

"Covered Person" means the policyholder, enrollee, claimant or their representatives, provider, agent or other entity which expresses a grievance or complaint involving the activities of the company or any persons involved in the solicitation, sale, service, execution of any transaction, or disposition of any funds of the policyholder.

"Grievance" means a written complaint on behalf of an insured person submitted by an insured person or a person, including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding:

(a) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination;

(b) claims payment, handling, or reimbursement for health care services;

(c) matters pertaining to the contractual relationship between a covered person and the insurer.

II. Review Process

You may ask your insurer to review its decisions involving your requests for benefit estimates or your requests to have your claims paid.

A written grievance concerning any matter, including an adverse determination may be submitted by a covered person. A written decision to the covered person will be provided within 15 working days after receiving a grievance and all information necessary for the insurer's review of the grievance. The person

or persons reviewing the grievance will not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. If a decision cannot be made within 15 working days due to circumstances beyond the insurer's control, the insurer may take up to an additional 15 working days to issue a written decision.

III. Written Decision

When a decision is issued after the review, the following information will be included in the written decision:

1. the names, titles and qualifying credentials of the persons participating in the grievance review process;
2. a statement of the reviewer's understanding of the grievance;
3. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision;
4. notice of the covered person's right to contact the Illinois Department of Insurance.

ILLINOIS
LIFE & HEALTH INSURANCE GUARANTY
ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

ILLINOIS LIFE AND
HEALTH INSURANCE GUARANTY ASSOCIATION

DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631-3404
(773) 714-8050

Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(217) 782-4515

Summary of General Purposes And
Current Limitations of Coverage

The Illinois law that provides for this safety net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") (215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions, and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

(please turn to other side)

1. Coverage:

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

a. life insurance, health insurance, and annuity contracts;
b. life, health or annuity certificates under direct group policies or contracts;
c. unallocated annuity contracts; and
d. contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

2. Exclusions from Coverage:

a. The Guaranty Association does not provide coverage for:

i. any policy or portion of a policy for which the individual has assumed the risk;
ii. any policy of reinsurance (unless an assumption certificate was issued);
iii. interest rate guarantees which exceed certain statutory limitations;
iv. certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
v. any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
vi. any stop loss insurance.

b. In addition, persons are not protected by the Guaranty Association if:

i. the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
ii. their policy was issued by an organization which is not a member insurer of the Association.

3. Limits on Amount of Coverage:

a. The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:

i. the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
ii. with respect to any one life, regardless of the number of policies, contracts, or certificates:

1) in the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or withdrawal values;
2) in the case of health insurance, $300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
3) with respect to annuities, $100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000 in benefits per contract holder, regardless of the number of contracts.

b. However, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

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

Benefit Class	Class Description
Class 1	Member Electing The Gold Plan
Class 2	Member Electing The Silver Plan
Class 3	Member Electing The Bronze Plan
Class 4	Member Electing The Value Plan
Class 5	Member Electing The Gold Plan
Class 6	Member Electing The Silver Plan
Class 7	Member Electing The Bronze Plan

Class Number 1

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

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

Maximum Amount - Each Benefit Period	$1,400

You and/or your dependents must be insured under the dental plan for 6 months to be eligible for Type 3 Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 2

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule
Maximum Amount - Each Benefit Period	$1,000

You and/or your dependents must be insured under the dental plan for 6 months to be eligible for Type 3 Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 3

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule
Maximum Amount - Each Benefit Period	$1,000

You and/or your dependents must be insured under the dental plan for 6 months to be eligible for Type 3 Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 4

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

Type 1 Procedures	$0
Type 2 Procedures - Each Benefit Period	$50

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Maximum Amount - Each Benefit Period	$1,000

Class Number 5

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

Coinsurance Percentage:

Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,400

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 6

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

Coinsurance Percentage:

Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,000

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 7

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

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

Maximum Amount - Each Benefit Period	$1,000

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 1

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 2

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 3

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 4

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 5

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 6

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 7

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 1

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 2

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 3

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 5

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 6

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 7

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Classes 01,05	
Dental Care Insurance	$42.74 per Insured Person
	$37.52 Spouse Only
	$57.83 Child(ren) Only
	$95.36 Spouse & Child(ren)
Classes 02,06	
Dental Care Insurance	$33.48 per Insured Person
	$29.28 Spouse Only
	$44.68 Child(ren) Only
	$73.96 Spouse & Child(ren)
Classes 03,07	
Dental Care Insurance	$26.24 per Insured Person
	$22.88 Spouse Only
	$34.56 Child(ren) Only
	$57.44 Spouse & Child(ren)
Class 4	
Dental Care Insurance	$15.84 per Insured Person
	$13.60 Spouse Only
	$27.36 Child(ren) Only
	$40.96 Spouse & Child(ren)
Classes 01,05	
Orthodontic Insurance	$0.00 per Insured Person
	$0.00 Spouse Only
	$5.44 Child(ren) Only

	$5.44 Spouse & Child(ren)
Classes 02,06	
Orthodontic Insurance	$0.00 per Insured Person
	$0.00 Spouse Only
	$5.40 Child(ren) Only
	$5.44 Spouse & Child(ren)
Classes 03,07	
Orthodontic Insurance	$0.00 per Insured Person
	$0.00 Spouse Only
	$5.40 Child(ren) Only
	$5.40 Spouse & Child(ren)
Classes 01,02,03,05,06,07	
Laser Vision Correction Insurance	$1.40 per Insured Person
	$1.40 Spouse Only
	$0.76 Child(ren) Only
	$2.16 Spouse & Child(ren)

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

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

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

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata

charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 30 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter if we determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0.

Should this occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 30 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such change in the above situation shall at all times be subject to applicable state laws and regulations.

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

DEFINITIONS

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

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

INSURED refers to a person:

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

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

c. for whom the insurance has become effective.

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

Class Number 1

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

   i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

   ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Class Number 2

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

   i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

   ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

Class Number 3

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

Class Number 4

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services

licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

Class Number 5

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

   i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

   ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

Class Number 6

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military

dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

Class Number 7

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

All Classes

TOTAL DISABILITY describes the Insured's Dependent as:

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

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

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

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

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

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

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

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

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

Class Number 1

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the gold plan.

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New Hampshire Residents are excluded from the Eligible Class for Insurance.

Deleted: If employment is the basis for membership, a member of the Eligible Class for Insurance is any member electing¶ the gold plan working a minimum number of hours per week as required by the Policyholder. If membership is¶ by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the¶ Policyholder¶

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

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

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the gold plan.

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New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

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

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

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

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

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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

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

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

Class Number 2

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the silver plan.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

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

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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

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the silver plan working a minimum number of hours per week as required by the Policyholder. If membership is¶
by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the¶
Policyholder¶

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

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the silver plan.

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New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

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

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

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

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

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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

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

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

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Class Number 3

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the silver plan.

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New Hampshire Residents are excluded from the Eligible Class for Insurance.

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

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

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the silver plan.

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New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

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

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

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

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

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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

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

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

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

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Class Number 4

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the bronze plan and has eligible dependents.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

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

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the value plan and has eligible dependents.

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New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

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

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

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

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

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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

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

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

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

Class Number 5

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the gold plan.

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New Hampshire Residents are excluded from the Eligible Class for Insurance.

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the gold plan working a minimum number of hours per week as required by the Policyholder. If membership is¶
by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the¶
Policyholder.¶

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

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

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the gold plan and has eligible dependents.

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New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Deleted: If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any¶
member electing the gold plan working a minimum number of hours per week as required by the Policyholder and¶
has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class¶
for Insurance is as defined by the Policyholder.¶

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

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

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

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

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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

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

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

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

Class Number 6

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the gold plan and has eligible dependents.

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Deleted: If employment is the basis for membership, a member of the Eligible Class for Insurance is any member electing¶
the silver plan working a minimum number of hours per week as required by the Policyholder. If membership is¶
by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the¶
Policyholder.¶

New Hampshire Residents are excluded from the Eligible Class for Insurance.

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

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

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the silver plan and has eligible dependents.

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New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

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

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

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

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

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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

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

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

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

Class Number 7

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the silver plan and has eligible dependents.

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New Hampshire Residents are excluded from the Eligible Class for Insurance.

Deleted: If employment is the basis for membership, a member of the Eligible Class for Insurance is any member electing¶ the bronze plan working a minimum number of hours per week as required by the Policyholder. If membership is¶ by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the¶ Policyholder¶

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered

from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

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

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the bronze plan and has eligible dependents.

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New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

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

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

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

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

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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

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

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

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All Classes

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

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

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

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

TERMINATION DATES

Class Number 1

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

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

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 2

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

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

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 3

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

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

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 4

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

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

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 5

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

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

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 6

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

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

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 7

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

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

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

All Classes

CONTINUATION OF COVERAGE

Death, Divorce or Separation
For Spouses and Dependents

1. The Insured's spouse may continue coverage for themselves and any dependent children if coverage would terminate as a result of:

a. the death of the Insured; or
b. the dissolution of a marriage with, or legal separation from, the Insured.
c. the retirement of the Insured. (In this instance, the spouse must be at least age 55 on the date of retirement in order to elect continuation under this provision.)

provided:

i. the spouse makes election for continuation of coverage in the required time frames; and
ii. any required premium is paid.

2. Benefits

This continuation applies to all benefits payable under the policy.

3. How to Apply

a. Within 30 days of the entry of judgment of divorce or legal separation, or the death or retirement of the Insured, the spouse must notify the policyholder, including a mailing address, if he or she wishes to elect continuation of coverage.

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b. Within 15 days of receipt of notice, the policyholder must mail us, the insurer, notice of the dissolution of the marriage or the death or retirement of the Insured.

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c. Within 30 days after the date of receipt of a notice from the policyholder, we shall provide notice in writing the following:

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i. an election form;
ii. the premium due;
iii. when and how payments must be made;
iv. instructions on returning the election form.

d. The spouse must affirmatively elect continuation with payment of the first monthly premium within 30 days of the date the notice is mailed by the insurer. Failure to elect continuation of coverage during this period shall terminate any future right to continuation.

4. Failure to Notify

If the insurer fails to send the notice of continuation, all premiums shall be waived from the date the notice was required until notice is sent.

5. Premiums

a. For former spouses who have not attained the age of 55 at the time coverage begins, the monthly premium shall be equal to the amount charged a member if the former spouse were a current member plus the amount the policyholder would contribute toward the premium if the former spouse were a current member.

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b. For former spouses who have attained the age of 55 at the time coverage begins, the monthly premium shall be based on the same calculation as defined in 5.a. above. However, beginning 2 years after coverage begins, the monthly premium shall be based on this same calculation, plus an additional amount, not to exceed 20% of this calculation for costs of administration.

6. Termination

For former spouses who have not attained age 55 at the time coverage begins, such insurance will stop on

the earliest of:

a. the last day of the period for which the premium is paid;
b. the date that coverage would terminate under the terms of the existing policy if the Insured and spouse were still married to each other;
c. the date the spouse becomes insured under another group health plan;
d. the date the spouse remarries;
e. the expiration of 2 years from the date coverage began;
f. the date the policy terminates.

For former spouses who have attained age 55 at the time coverage begins, such insurance will stop on the earliest of:

a. the last day of the period for which the premium is paid;
b. the date on which coverage would terminate, except due to the retirement of an employee, under the terms of the existing policy if the Insured and spouse were still married to each other;
c. the date the spouse becomes insured under another group health plan;
d. the date the spouse remarries;
e. the date the spouse is eligible for coverage under Medicare, Title XVIII of the Federal Social Security Act;
f. the date the policy terminates.

7. Replacement of Policy
A new insurance carrier replacing coverage under which a continued person is covered must take over and continue such person's coverage.

Death of the Insured
Attainment of Limiting Age
Dependent Children

1. The Insured's dependent child may continue coverage under this policy
   a. in the event of the death of the Insured and the child is not eligible for coverage as a dependent under the provisions stated above; or
   b. the dependent child has attained the limiting age under the policy.

2. This continuation applies to all benefits payable under the policy.

3. How to Apply
   a. Death of the Insured
      Within 30 days of the death of the Insured, the dependent child or a responsible adult acting on behalf of the child must notify the policyholder or the insurer if he or she wishes to elect continuation of coverage.

      Within 15 days of receipt of notice, the policyholder must mail us, the insurer, notice of the death of the Insured and the mailing address of the dependent child. The policyholder shall immediately send a copy of the notice to the dependent child or responsible adult at the dependent child's residence.

   b. Attainment of Limiting Age
      In the event of the dependent child attaining the limiting age under the policy, if continuation coverage is desired, the dependent child shall give the employer or the insurer written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.

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Within 15 days of receipt of notice, the policyholder must mail us, the insurer, notice of the request to continue coverage under this provision including the mailing address of the dependent child. The policyholer shall immediately send a copy of the notice to the dependent child or responsible adult at the dependent child's residence

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4. Responsibilities of the Insurer

Within 30 days after the date of receipt of a notice from the policyholder, we shall provide notice in writing by certified mail, return receipt requested, notification to the dependent child or responsible adult that the policy may be continued. In addition, the notice will include:

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i. an election form;
ii. the premium due;
iii. when and how payments must be made;
iv. instructions on returning the election form within thirty (30) days after the date it is received.

5. Electing Coverage

The dependent child or the responsible adult acting on behalf of the dependent child to exercise the election to continue coverage within such 30 day period shall terminate the continuation of benefits and the right to continuation.

6. Failure to Notify

If the insurer fails to send the notice of continuation, all premiums shall be waived from the date the notice was required until notice is sent and benefits will continue under the terms and provisions of the policy except where the benefits in existence at the time the company's notice was to be sent are terminated as to all members.

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7. Premiums

The monthly premium will be equal to:

a. an amount, if any, that would be charged a member if the dependent child were a current member of the policyholder, plus;

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b. an amount, if any, that the employer would contribute toward the premium if the dependent child were a current member..

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Failure to pay the initial monthly premium within 30 days after the date of receipt of notice as defined in subsection (4) of this provision terminates the continuation benefits and the right to continuation benefits.

8. Termination

Coverage under this provision will terminate upon the earliest of:

a. the last day of the period for which the premium is paid;
b. the date that coverage would terminate under the terms of the existing policy if the dependent child was still an eligible dependent of the member;

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c. the date on which the dependent child first becomes, or after the date of election, an insured member under any other group policy; or

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d. the expiration of 2 years from the date continuation coverage began.

9. Replacement of Policy

If the group policy is cancelled and another insurance company contracts to provide group coverage to the policyholder, and continuation coverage is in effect for the dependent child at the time of cancellation, and the member is or would have been included under the new group policy, then the new insurer must also offer continuation coverage to the dependent child under the same terms and conditions as contained in this provision.

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DENTAL EXPENSE BENEFITS

Class Number 1

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

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

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

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

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

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

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

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

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

1. for Type 3 Procedures in the first 6 months the person is covered under this contract.

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

3. for appliances, restorations, or procedures to:

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

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

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

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

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

provision found on 9260).

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

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

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

12. because of war or any act of war, declared or not.

Class Number 2

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

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

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is

amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

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

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

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

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

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group’s termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

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

1. for Type 3 Procedures in the first 6 months the person is covered under this contract.

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

3. for appliances, restorations, or procedures to:

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

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

this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

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

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

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

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

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

12. because of war or any act of war, declared or not.

Class Number 3

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

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

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

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

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

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

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

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

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

1. for Type 3 Procedures in the first 6 months the person is covered under this contract.

2. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any

such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

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

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

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

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

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

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

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

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

12. because of war or any act of war, declared or not.

Class Number 4

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

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

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

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

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

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

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

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

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

1. for appliances, restorations, or procedures to:

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

2. for any procedure begun after the insured person's insurance under this contract terminates.

3. to replace lost or stolen appliances.

4. for any treatment which is for cosmetic purposes.

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

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

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

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

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

10. because of war or any act of war, declared or not.

<u>Class Number 5</u>

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

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

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

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

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

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown,

appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

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

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

2. for appliances, restorations, or procedures to:

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

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

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

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

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

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

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

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

11. because of war or any act of war, declared or not.

<u>Class Number 6</u>

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

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

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

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

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

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

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

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

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

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

2. for appliances, restorations, or procedures to:

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

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

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

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

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

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

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

10. for services that are not required for necessary care and treatment or are not within the generally

accepted parameters of care.

11. because of war or any act of war, declared or not.

Class Number 7

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

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

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

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

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

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

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

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

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

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

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

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

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

2. for appliances, restorations, or procedures to:

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

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

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

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

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

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

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

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

11. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

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

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

Class Number 1

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 2

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 3

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 4

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 5

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 6

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

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

Class Number 7

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

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

All Classes

- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.

- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).

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

- B/R means By Report.

- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.

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

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

Class Number 1

TYPE 1 PROCEDURES

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

ROUTINE ORAL EVALUATION		Maximum Covered Expense
D0120	Periodic oral evaluation - established patient.	$33.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$25.00
D0150	Comprehensive oral evaluation - new or established patient.	$50.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$50.00

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

BITEWING FILMS		
D0270	Bitewing - single film.	$16.00
D0272	Bitewings - two films.	$30.00
D0273	Bitewings - three films.	$36.00
D0274	Bitewings - four films.	$46.00
D0277	Vertical bitewings - 7 to 8 films.	$70.00

BITEWING FILMS: D0270, D0272, D0273, D0274

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

VERTICAL BITEWING FILM: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$70.00
D1120	Prophylaxis - child.	$49.00
D1203	Topical application of fluoride - child.	$27.00
D1204	Topical application of fluoride - adult.	$27.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$27.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$38.00

SEALANT: D1351

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

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$246.00
D1515	Space maintainer - fixed - bilateral.	$402.00
D1520	Space maintainer - removable - unilateral.	$385.00
D1525	Space maintainer - removable - bilateral.	$469.00
D1550	Re-cementation of space maintainer.	$50.00
D1555	Removal of fixed space maintainer.	$70.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$370.00
D8220	Fixed appliance therapy.	$370.00

APPLIANCE THERAPY: D8210, D8220

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

TYPE 2 PROCEDURES

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

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$41.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$41.00

LIMITED ORAL EVALUATION: D0140, D0170

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

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$83.00
D0330	Panoramic film.	$67.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

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

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$15.00
D0230	Intraoral - periapical each additional film.	$12.00
D0240	Intraoral - occlusal film.	$21.00
D0250	Extraoral - first film.	$27.00
D0260	Extraoral - each additional film.	$21.00

PERIAPICAL FILMS: D0220, D0230

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

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$49.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$97.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$97.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$70.00
D2150	Amalgam - two surfaces, primary or permanent.	$89.00
D2160	Amalgam - three surfaces, primary or permanent.	$107.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$128.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$85.00
D2331	Resin-based composite - two surfaces, anterior.	$107.00
D2332	Resin-based composite - three surfaces, anterior.	$134.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$148.00
D2391	Resin-based composite - one surface, posterior.	$93.00
D2392	Resin-based composite - two surfaces, posterior.	$118.00
D2393	Resin-based composite - three surfaces, posterior.	$148.00
D2394	Resin-based composite - four or more surfaces, posterior.	$163.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$70.00
D2420	Gold foil - two surfaces.	$89.00
D2430	Gold foil - three surfaces.	$107.00

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$181.00
D2930	Prefabricated stainless steel crown - primary tooth.	$152.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$161.00
D2932	Prefabricated resin crown.	$181.00
D2933	Prefabricated stainless steel crown with resin window.	$181.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$181.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$56.00
D2915	Recement cast or prefabricated post and core.	$28.00
D2920	Recement crown.	$55.00
D6092	Recement implant/abutment supported crown.	$55.00
D6093	Recement implant/abutment supported fixed partial denture.	$55.00
D6930	Recement fixed partial denture.	$76.00

SEDATIVE FILLING

D2940	Sedative filling.	$51.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$86.00

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$89.00

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	$89.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$74.00
D5610	Repair resin denture base.	$88.00
D5620	Repair cast framework.	$104.00
D5630	Repair or replace broken clasp.	$109.00
D5640	Replace broken teeth - per tooth.	$78.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$163.00
D5731	Reline complete mandibular denture (chairside).	$162.00
D5740	Reline maxillary partial denture (chairside).	$146.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$147.00
D5750	Reline complete maxillary denture (laboratory).	$243.00
D5751	Reline complete mandibular denture (laboratory).	$238.00
D5760	Reline maxillary partial denture (laboratory).	$243.00
D5761	Reline mandibular partial denture (laboratory).	$244.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$78.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$78.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$151.00
D7220	Removal of impacted tooth - soft tissue.	$188.00
D7230	Removal of impacted tooth - partially bony.	$250.00
D7240	Removal of impacted tooth - completely bony.	$292.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$333.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$156.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$369.00
D7261	Primary closure of a sinus perforation.	$369.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$223.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$223.00
D7280	Surgical access of an unerupted tooth.	$345.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$249.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$104.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$130.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$65.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$165.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$83.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$238.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$592.00
D7410	Excision of benign lesion up to 1.25 cm.	$236.00
D7411	Excision of benign lesion greater than 1.25 cm.	$302.00
D7412	Excision of benign lesion, complicated.	$333.00
D7413	Excision of malignant lesion up to 1.25 cm.	$319.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$233.00
D7415	Excision of malignant lesion, complicated.	$257.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$319.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$233.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$71.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$210.00
D7472	Removal of torus palatinus.	$210.00
D7473	Removal of torus mandibularis.	$210.00
D7485	Surgical reduction of osseous tuberosity.	$342.00
D7490	Radical resection of maxilla or mandible.	$319.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$105.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$121.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$97.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$266.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$266.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$350.00
D7910	Suture of recent small wounds up to 5 cm.	$47.00
D7911	Complicated suture - up to 5 cm.	$53.00
D7912	Complicated suture - greater than 5 cm.	$76.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$253.00
D7963	Frenuloplasty.	$316.00
D7970	Excision of hyperplastic tissue - per arch.	$195.00
D7972	Surgical reduction of fibrous tuberosity.	$310.00
D7980	Sialolithotomy.	$292.00
D7983	Closure of salivary fistula.	$93.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$316.00
D7286	Biopsy of oral tissue - soft.	$170.00
D7287	Exfoliative cytological sample collection.	$85.00
D7288	Brush biopsy - transepithelial sample collection.	$85.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$58.00

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$224.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$74.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$148.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$36.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$60.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$41.00
D9440	Office visit - after regularly scheduled hours.	$72.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$44.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$56.00
D9952	Occlusal adjustment - complete.	$281.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$49.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$27.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$85.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$305.00
D2520	Inlay - metallic - two surfaces.	$363.00
D2530	Inlay - metallic - three or more surfaces.	$391.00
D2610	Inlay - porcelain/ceramic - one surface.	$336.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$366.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$401.00
D2650	Inlay - resin-based composite - one surface.	$349.00
D2651	Inlay - resin-based composite - two surfaces.	$345.00
D2652	Inlay - resin-based composite - three or more surfaces.	$357.00

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

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

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$396.00
D2543	Onlay - metallic - three surfaces.	$441.00
D2544	Onlay - metallic - four or more surfaces.	$459.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$396.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$443.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$456.00
D2662	Onlay - resin-based composite - two surfaces.	$371.00
D2663	Onlay - resin-based composite - three surfaces.	$382.00
D2664	Onlay - resin-based composite - four or more surfaces.	$406.00

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

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

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$173.00
D2712	Crown - 3/4 resin-based composite (indirect).	$428.00
D2720	Crown - resin with high noble metal.	$441.00
D2721	Crown - resin with predominantly base metal.	$336.00
D2722	Crown - resin with noble metal.	$413.00
D2740	Crown - porcelain/ceramic substrate.	$476.00
D2750	Crown - porcelain fused to high noble metal.	$463.00
D2751	Crown - porcelain fused to predominantly base metal.	$397.00
D2752	Crown - porcelain fused to noble metal.	$425.00
D2780	Crown - 3/4 cast high noble metal.	$440.00
D2781	Crown - 3/4 cast predominantly base metal.	$383.00
D2782	Crown - 3/4 cast noble metal.	$400.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$476.00
D2790	Crown - full cast high noble metal.	$440.00
D2791	Crown - full cast predominantly base metal.	$383.00
D2792	Crown - full cast noble metal.	$400.00
D2794	Crown - titanium.	$440.00

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

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

CORE BUILD-UP

D2950	Core buildup, including any pins.	$96.00
D6973	Core build up for retainer, including any pins.	$96.00

CORE BUILDUP: D2950, D6973

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

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$153.00
D2954	Prefabricated post and core in addition to crown.	$127.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$77.00
D6980	Fixed partial denture repair, by report.	$86.00
D9120	Fixed partial denture sectioning.	$86.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$61.00
D3221	Pulpal debridement, primary and permanent teeth.	$61.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$91.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$81.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$70.00
D3333	Internal root repair of perforation defects.	$99.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$99.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$67.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$197.00
D3430	Retrograde filling - per root.	$78.00
D3450	Root amputation - per root.	$185.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$156.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$277.00
D3320	Endodontic therapy, bicuspid tooth.	$326.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$427.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$163.00
D3346	Retreatment of previous root canal therapy - anterior.	$345.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$397.00
D3348	Retreatment of previous root canal therapy - molar.	$493.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$285.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$328.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$355.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$127.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$180.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$90.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$247.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$124.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$454.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$227.00
D4263	Bone replacement graft - first site in quadrant.	$148.00
D4264	Bone replacement graft - each additional site in quadrant.	$111.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$74.00
D4270	Pedicle soft tissue graft procedure.	$334.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$354.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$413.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$199.00
D4275	Soft tissue allograft.	$354.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$413.00

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

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

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$273.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$93.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$46.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$68.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$493.00
D5120	Complete denture - mandibular.	$478.00
D5130	Immediate denture - maxillary.	$534.00
D5140	Immediate denture - mandibular.	$517.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$354.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$410.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$354.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$410.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$306.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$354.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$410.00
D5810	Interim complete denture (maxillary).	$218.00
D5811	Interim complete denture (mandibular).	$230.00
D5820	Interim partial denture (maxillary).	$191.00
D5821	Interim partial denture (mandibular).	$201.00
D5860	Overdenture - complete, by report.	$493.00
D5861	Overdenture - partial, by report.	$571.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$493.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$571.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$493.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$571.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$28.00
D5411	Adjust complete denture - mandibular.	$26.00
D5421	Adjust partial denture - maxillary.	$29.00
D5422	Adjust partial denture - mandibular.	$28.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$64.00
D5660	Add clasp to existing partial denture.	$74.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$179.00
D5711	Rebase complete mandibular denture.	$190.00
D5720	Rebase maxillary partial denture.	$171.00
D5721	Rebase mandibular partial denture.	$181.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$50.00
D5851	Tissue conditioning, mandibular.	$54.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$411.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$449.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$449.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$411.00
D6062	Abutment supported cast metal crown (high noble metal).	$449.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$449.00
D6064	Abutment supported cast metal crown (noble metal).	$486.00
D6065	Implant supported porcelain/ceramic crown.	$411.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$411.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$449.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$449.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$411.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$449.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$449.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$486.00
D6075	Implant supported retainer for ceramic FPD.	$411.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$449.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$449.00
D6094	Abutment supported crown - (titanium).	$449.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$449.00
D6205	Pontic - indirect resin based composite.	$370.00
D6210	Pontic - cast high noble metal.	$449.00
D6211	Pontic - cast predominantly base metal.	$449.00
D6212	Pontic - cast noble metal.	$486.00
D6214	Pontic - titanium.	$449.00
D6240	Pontic - porcelain fused to high noble metal.	$449.00
D6241	Pontic - porcelain fused to predominantly base metal.	$449.00
D6242	Pontic - porcelain fused to noble metal.	$411.00
D6245	Pontic - porcelain/ceramic.	$411.00
D6250	Pontic - resin with high noble metal.	$449.00
D6251	Pontic - resin with predominantly base metal.	$411.00
D6252	Pontic - resin with noble metal.	$486.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$150.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$150.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$366.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$402.00
D6602	Inlay - cast high noble metal, two surfaces.	$329.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$362.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$284.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$313.00
D6606	Inlay - cast noble metal, two surfaces.	$299.00
D6607	Inlay - cast noble metal, three or more surfaces.	$329.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$396.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$435.00
D6610	Onlay - cast high noble metal, two surfaces.	$362.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$398.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$313.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$344.00
D6614	Onlay - cast noble metal, two surfaces.	$329.00
D6615	Onlay - cast noble metal, three or more surfaces.	$362.00
D6624	Inlay - titanium.	$362.00
D6634	Onlay - titanium.	$398.00
D6710	Crown - indirect resin based composite.	$370.00
D6720	Crown - resin with high noble metal.	$449.00
D6721	Crown - resin with predominantly base metal.	$233.00
D6722	Crown - resin with noble metal.	$374.00
D6740	Crown - porcelain/ceramic.	$411.00
D6750	Crown - porcelain fused to high noble metal.	$486.00
D6751	Crown - porcelain fused to predominantly base metal.	$449.00
D6752	Crown - porcelain fused to noble metal.	$411.00
D6780	Crown - 3/4 cast high noble metal.	$486.00
D6781	Crown - 3/4 cast predominantly base metal.	$449.00
D6782	Crown - 3/4 cast noble metal.	$411.00
D6783	Crown - 3/4 porcelain/ceramic.	$411.00
D6790	Crown - full cast high noble metal.	$449.00
D6791	Crown - full cast predominantly base metal.	$449.00
D6792	Crown - full cast noble metal.	$411.00
D6794	Crown - titanium.	$449.00
D6940	Stress breaker.	$124.00

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

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

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

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

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

TYPE 3 PROCEDURES

Maximum Covered Expense

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

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

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

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

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

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

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

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$135.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$135.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$72.00
D9973	External bleaching - per tooth.	$45.00
D9974	Internal bleaching - per tooth.	$54.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 2

TYPE 1 PROCEDURES

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

ROUTINE ORAL EVALUATION		Maximum Covered Expense
D0120	Periodic oral evaluation - established patient.	$28.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$22.00
D0150	Comprehensive oral evaluation - new or established patient.	$43.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$43.00

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

BITEWING FILMS		
D0270	Bitewing - single film.	$14.00
D0272	Bitewings - two films.	$26.00
D0273	Bitewings - three films.	$31.00
D0274	Bitewings - four films.	$40.00
D0277	Vertical bitewings - 7 to 8 films.	$60.00

BITEWING FILMS: D0270, D0272, D0273, D0274

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

VERTICAL BITEWING FILM: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$60.00
D1120	Prophylaxis - child.	$42.00
D1203	Topical application of fluoride - child.	$23.00
D1204	Topical application of fluoride - adult.	$23.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$23.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$33.00

SEALANT: D1351

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

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$212.00
D1515	Space maintainer - fixed - bilateral.	$347.00
D1520	Space maintainer - removable - unilateral.	$332.00
D1525	Space maintainer - removable - bilateral.	$405.00
D1550	Re-cementation of space maintainer.	$43.00
D1555	Removal of fixed space maintainer.	$60.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$319.00
D8220	Fixed appliance therapy.	$319.00

APPLIANCE THERAPY: D8210, D8220

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

TYPE 2 PROCEDURES

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

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$35.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$35.00

LIMITED ORAL EVALUATION: D0140, D0170

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

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$71.00
D0330	Panoramic film.	$57.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

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

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$13.00
D0230	Intraoral - periapical each additional film.	$10.00
D0240	Intraoral - occlusal film.	$18.00
D0250	Extraoral - first film.	$23.00
D0260	Extraoral - each additional film.	$18.00

PERIAPICAL FILMS: D0220, D0230

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

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$42.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$83.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$83.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$60.00
D2150	Amalgam - two surfaces, primary or permanent.	$76.00
D2160	Amalgam - three surfaces, primary or permanent.	$92.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$110.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$73.00
D2331	Resin-based composite - two surfaces, anterior.	$92.00
D2332	Resin-based composite - three surfaces, anterior.	$115.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$127.00
D2391	Resin-based composite - one surface, posterior.	$80.00
D2392	Resin-based composite - two surfaces, posterior.	$101.00
D2393	Resin-based composite - three surfaces, posterior.	$127.00
D2394	Resin-based composite - four or more surfaces, posterior.	$140.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$60.00
D2420	Gold foil - two surfaces.	$76.00
D2430	Gold foil - three surfaces.	$92.00

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$155.00
D2930	Prefabricated stainless steel crown - primary tooth.	$130.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$138.00
D2932	Prefabricated resin crown.	$155.00
D2933	Prefabricated stainless steel crown with resin window.	$155.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$155.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$48.00
D2915	Recement cast or prefabricated post and core.	$24.00
D2920	Recement crown.	$47.00
D6092	Recement implant/abutment supported crown.	$47.00
D6093	Recement implant/abutment supported fixed partial denture.	$47.00
D6930	Recement fixed partial denture.	$65.00

SEDATIVE FILLING

D2940	Sedative filling.	$44.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$74.00

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$76.00

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	$76.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$63.00
D5610	Repair resin denture base.	$75.00
D5620	Repair cast framework.	$89.00
D5630	Repair or replace broken clasp.	$93.00
D5640	Replace broken teeth - per tooth.	$67.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$140.00
D5731	Reline complete mandibular denture (chairside).	$139.00
D5740	Reline maxillary partial denture (chairside).	$125.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$126.00
D5750	Reline complete maxillary denture (laboratory).	$208.00
D5751	Reline complete mandibular denture (laboratory).	$204.00
D5760	Reline maxillary partial denture (laboratory).	$208.00
D5761	Reline mandibular partial denture (laboratory).	$209.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$67.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$67.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$129.00
D7220	Removal of impacted tooth - soft tissue.	$161.00
D7230	Removal of impacted tooth - partially bony.	$214.00
D7240	Removal of impacted tooth - completely bony.	$250.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$285.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$134.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$316.00
D7261	Primary closure of a sinus perforation.	$316.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$191.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$191.00
D7280	Surgical access of an unerupted tooth.	$296.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$213.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$89.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$111.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$56.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$141.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$71.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$204.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$507.00
D7410	Excision of benign lesion up to 1.25 cm.	$202.00
D7411	Excision of benign lesion greater than 1.25 cm.	$259.00
D7412	Excision of benign lesion, complicated.	$285.00
D7413	Excision of malignant lesion up to 1.25 cm.	$273.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$200.00
D7415	Excision of malignant lesion, complicated.	$220.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$273.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$200.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$61.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$180.00
D7472	Removal of torus palatinus.	$180.00
D7473	Removal of torus mandibularis.	$180.00
D7485	Surgical reduction of osseous tuberosity.	$293.00
D7490	Radical resection of maxilla or mandible.	$273.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$90.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$104.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$83.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$228.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$228.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$300.00
D7910	Suture of recent small wounds up to 5 cm.	$40.00
D7911	Complicated suture - up to 5 cm.	$45.00
D7912	Complicated suture - greater than 5 cm.	$65.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$217.00
D7963	Frenuloplasty.	$271.00
D7970	Excision of hyperplastic tissue - per arch.	$167.00
D7972	Surgical reduction of fibrous tuberosity.	$266.00
D7980	Sialolithotomy.	$250.00
D7983	Closure of salivary fistula.	$80.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$271.00
D7286	Biopsy of oral tissue - soft.	$146.00
D7287	Exfoliative cytological sample collection.	$73.00
D7288	Brush biopsy - transepithelial sample collection.	$73.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$50.00

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$192.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$63.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$127.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$31.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$51.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$35.00
D9440	Office visit - after regularly scheduled hours.	$62.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$38.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$48.00
D9952	Occlusal adjustment - complete.	$241.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$42.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$23.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$73.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$248.00
D2520	Inlay - metallic - two surfaces.	$295.00
D2530	Inlay - metallic - three or more surfaces.	$318.00
D2610	Inlay - porcelain/ceramic - one surface.	$273.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$297.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$326.00
D2650	Inlay - resin-based composite - one surface.	$284.00
D2651	Inlay - resin-based composite - two surfaces.	$280.00
D2652	Inlay - resin-based composite - three or more surfaces.	$290.00

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

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

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$321.00
D2543	Onlay - metallic - three surfaces.	$358.00
D2544	Onlay - metallic - four or more surfaces.	$373.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$321.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$360.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$371.00
D2662	Onlay - resin-based composite - two surfaces.	$301.00
D2663	Onlay - resin-based composite - three surfaces.	$310.00
D2664	Onlay - resin-based composite - four or more surfaces.	$330.00

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

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

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$140.00
D2712	Crown - 3/4 resin-based composite (indirect).	$348.00
D2720	Crown - resin with high noble metal.	$358.00
D2721	Crown - resin with predominantly base metal.	$273.00
D2722	Crown - resin with noble metal.	$335.00
D2740	Crown - porcelain/ceramic substrate.	$387.00
D2750	Crown - porcelain fused to high noble metal.	$376.00
D2751	Crown - porcelain fused to predominantly base metal.	$323.00
D2752	Crown - porcelain fused to noble metal.	$346.00
D2780	Crown - 3/4 cast high noble metal.	$358.00
D2781	Crown - 3/4 cast predominantly base metal.	$311.00
D2782	Crown - 3/4 cast noble metal.	$325.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$387.00
D2790	Crown - full cast high noble metal.	$358.00
D2791	Crown - full cast predominantly base metal.	$311.00
D2792	Crown - full cast noble metal.	$325.00
D2794	Crown - titanium.	$358.00

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

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

CORE BUILD-UP

D2950	Core buildup, including any pins.	$78.00
D6973	Core build up for retainer, including any pins.	$78.00

CORE BUILDUP: D2950, D6973

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

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$124.00
D2954	Prefabricated post and core in addition to crown.	$103.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$63.00
D6980	Fixed partial denture repair, by report.	$70.00
D9120	Fixed partial denture sectioning.	$70.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$49.00
D3221	Pulpal debridement, primary and permanent teeth.	$49.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$74.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$66.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$57.00
D3333	Internal root repair of perforation defects.	$81.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$81.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$55.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$160.00
D3430	Retrograde filling - per root.	$63.00
D3450	Root amputation - per root.	$150.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$127.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$225.00
D3320	Endodontic therapy, bicuspid tooth.	$265.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$347.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$132.00
D3346	Retreatment of previous root canal therapy - anterior.	$280.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$323.00
D3348	Retreatment of previous root canal therapy - molar.	$400.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$231.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$267.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$289.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$103.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$146.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$74.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$201.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$101.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$369.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$185.00
D4263	Bone replacement graft - first site in quadrant.	$120.00
D4264	Bone replacement graft - each additional site in quadrant.	$91.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$60.00
D4270	Pedicle soft tissue graft procedure.	$272.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$287.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$335.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$162.00
D4275	Soft tissue allograft.	$287.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$335.00

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

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

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$222.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$75.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$38.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$55.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$400.00
D5120	Complete denture - mandibular.	$388.00
D5130	Immediate denture - maxillary.	$434.00
D5140	Immediate denture - mandibular.	$420.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$288.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$334.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$288.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$334.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$248.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$288.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$334.00
D5810	Interim complete denture (maxillary).	$177.00
D5811	Interim complete denture (mandibular).	$187.00
D5820	Interim partial denture (maxillary).	$156.00
D5821	Interim partial denture (mandibular).	$163.00
D5860	Overdenture - complete, by report.	$400.00
D5861	Overdenture - partial, by report.	$464.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$400.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$464.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$400.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$464.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$22.00
D5411	Adjust complete denture - mandibular.	$21.00
D5421	Adjust partial denture - maxillary.	$24.00
D5422	Adjust partial denture - mandibular.	$22.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$52.00
D5660	Add clasp to existing partial denture.	$60.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$146.00
D5711	Rebase complete mandibular denture.	$154.00
D5720	Rebase maxillary partial denture.	$139.00
D5721	Rebase mandibular partial denture.	$147.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$41.00
D5851	Tissue conditioning, mandibular.	$44.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$334.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$365.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$365.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$334.00
D6062	Abutment supported cast metal crown (high noble metal).	$365.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$365.00
D6064	Abutment supported cast metal crown (noble metal).	$395.00
D6065	Implant supported porcelain/ceramic crown.	$334.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$334.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$365.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$365.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$334.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$365.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$365.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$395.00
D6075	Implant supported retainer for ceramic FPD.	$334.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$365.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$365.00
D6094	Abutment supported crown - (titanium).	$365.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$365.00
D6205	Pontic - indirect resin based composite.	$301.00
D6210	Pontic - cast high noble metal.	$365.00
D6211	Pontic - cast predominantly base metal.	$365.00
D6212	Pontic - cast noble metal.	$395.00
D6214	Pontic - titanium.	$365.00
D6240	Pontic - porcelain fused to high noble metal.	$365.00
D6241	Pontic - porcelain fused to predominantly base metal.	$365.00
D6242	Pontic - porcelain fused to noble metal.	$334.00
D6245	Pontic - porcelain/ceramic.	$334.00
D6250	Pontic - resin with high noble metal.	$365.00
D6251	Pontic - resin with predominantly base metal.	$334.00
D6252	Pontic - resin with noble metal.	$395.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$122.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$122.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$297.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$327.00
D6602	Inlay - cast high noble metal, two surfaces.	$267.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$294.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$231.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$254.00
D6606	Inlay - cast noble metal, two surfaces.	$243.00
D6607	Inlay - cast noble metal, three or more surfaces.	$267.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$321.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$354.00
D6610	Onlay - cast high noble metal, two surfaces.	$294.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$323.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$254.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$279.00
D6614	Onlay - cast noble metal, two surfaces.	$267.00
D6615	Onlay - cast noble metal, three or more surfaces.	$294.00
D6624	Inlay - titanium.	$294.00
D6634	Onlay - titanium.	$323.00
D6710	Crown - indirect resin based composite.	$301.00
D6720	Crown - resin with high noble metal.	$365.00
D6721	Crown - resin with predominantly base metal.	$189.00
D6722	Crown - resin with noble metal.	$304.00
D6740	Crown - porcelain/ceramic.	$334.00
D6750	Crown - porcelain fused to high noble metal.	$395.00
D6751	Crown - porcelain fused to predominantly base metal.	$365.00
D6752	Crown - porcelain fused to noble metal.	$334.00
D6780	Crown - 3/4 cast high noble metal.	$395.00
D6781	Crown - 3/4 cast predominantly base metal.	$365.00
D6782	Crown - 3/4 cast noble metal.	$334.00
D6783	Crown - 3/4 porcelain/ceramic.	$334.00
D6790	Crown - full cast high noble metal.	$365.00
D6791	Crown - full cast predominantly base metal.	$365.00
D6792	Crown - full cast noble metal.	$334.00
D6794	Crown - titanium.	$365.00
D6940	Stress breaker.	$101.00

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

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

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

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

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

TYPE 3 PROCEDURES

Maximum Covered Expense

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

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

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

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

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

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

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

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$109.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$109.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$58.00
D9973	External bleaching - per tooth.	$36.00
D9974	Internal bleaching - per tooth.	$44.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 3

TYPE 1 PROCEDURES

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

ROUTINE ORAL EVALUATION		Maximum Covered Expense
D0120	Periodic oral evaluation - established patient.	$23.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$18.00
D0150	Comprehensive oral evaluation - new or established patient.	$36.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$36.00

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

BITEWING FILMS		
D0270	Bitewing - single film.	$12.00
D0272	Bitewings - two films.	$21.00
D0273	Bitewings - three films.	$26.00
D0274	Bitewings - four films.	$33.00
D0277	Vertical bitewings - 7 to 8 films.	$50.00

BITEWING FILMS: D0270, D0272, D0273, D0274

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

VERTICAL BITEWING FILM: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$50.00
D1120	Prophylaxis - child.	$35.00
D1203	Topical application of fluoride - child.	$19.00
D1204	Topical application of fluoride - adult.	$19.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$19.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$28.00

SEALANT: D1351

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

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$177.00
D1515	Space maintainer - fixed - bilateral.	$289.00
D1520	Space maintainer - removable - unilateral.	$277.00
D1525	Space maintainer - removable - bilateral.	$337.00
D1550	Re-cementation of space maintainer.	$36.00
D1555	Removal of fixed space maintainer.	$50.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$266.00
D8220	Fixed appliance therapy.	$266.00

APPLIANCE THERAPY: D8210, D8220

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

TYPE 2 PROCEDURES

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

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$29.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$29.00

LIMITED ORAL EVALUATION: D0140, D0170

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

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$59.00
D0330	Panoramic film.	$47.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

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

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$11.00
D0230	Intraoral - periapical each additional film.	$8.00
D0240	Intraoral - occlusal film.	$15.00
D0250	Extraoral - first film.	$19.00
D0260	Extraoral - each additional film.	$15.00

PERIAPICAL FILMS: D0220, D0230

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

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$35.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$69.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$69.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$50.00
D2150	Amalgam - two surfaces, primary or permanent.	$63.00
D2160	Amalgam - three surfaces, primary or permanent.	$77.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$92.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$61.00
D2331	Resin-based composite - two surfaces, anterior.	$77.00
D2332	Resin-based composite - three surfaces, anterior.	$96.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$106.00
D2391	Resin-based composite - one surface, posterior.	$67.00
D2392	Resin-based composite - two surfaces, posterior.	$84.00
D2393	Resin-based composite - three surfaces, posterior.	$106.00
D2394	Resin-based composite - four or more surfaces, posterior.	$117.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$50.00
D2420	Gold foil - two surfaces.	$63.00
D2430	Gold foil - three surfaces.	$77.00

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$129.00
D2930	Prefabricated stainless steel crown - primary tooth.	$108.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$115.00
D2932	Prefabricated resin crown.	$129.00
D2933	Prefabricated stainless steel crown with resin window.	$129.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$129.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$40.00
D2915	Recement cast or prefabricated post and core.	$20.00
D2920	Recement crown.	$39.00
D6092	Recement implant/abutment supported crown.	$39.00
D6093	Recement implant/abutment supported fixed partial denture.	$39.00
D6930	Recement fixed partial denture.	$54.00

SEDATIVE FILLING

D2940	Sedative filling.	$37.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$62.00

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$63.00

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	$63.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$52.00
D5610	Repair resin denture base.	$62.00
D5620	Repair cast framework.	$74.00
D5630	Repair or replace broken clasp.	$77.00
D5640	Replace broken teeth - per tooth.	$56.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$117.00
D5731	Reline complete mandibular denture (chairside).	$116.00
D5740	Reline maxillary partial denture (chairside).	$104.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$105.00
D5750	Reline complete maxillary denture (laboratory).	$173.00
D5751	Reline complete mandibular denture (laboratory).	$170.00
D5760	Reline maxillary partial denture (laboratory).	$173.00
D5761	Reline mandibular partial denture (laboratory).	$174.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$56.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$56.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$107.00
D7220	Removal of impacted tooth - soft tissue.	$134.00
D7230	Removal of impacted tooth - partially bony.	$178.00
D7240	Removal of impacted tooth - completely bony.	$208.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$237.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$112.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$263.00
D7261	Primary closure of a sinus perforation.	$263.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$159.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$159.00
D7280	Surgical access of an unerupted tooth.	$247.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$177.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$74.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$92.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$47.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$117.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$59.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$170.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$422.00
D7410	Excision of benign lesion up to 1.25 cm.	$168.00
D7411	Excision of benign lesion greater than 1.25 cm.	$216.00
D7412	Excision of benign lesion, complicated.	$237.00
D7413	Excision of malignant lesion up to 1.25 cm.	$227.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$167.00
D7415	Excision of malignant lesion, complicated.	$183.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$227.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$167.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$51.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$150.00
D7472	Removal of torus palatinus.	$150.00
D7473	Removal of torus mandibularis.	$150.00
D7485	Surgical reduction of osseous tuberosity.	$244.00
D7490	Radical resection of maxilla or mandible.	$227.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$75.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$87.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$69.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$190.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$190.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$250.00
D7910	Suture of recent small wounds up to 5 cm.	$33.00
D7911	Complicated suture - up to 5 cm.	$37.00
D7912	Complicated suture - greater than 5 cm.	$54.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$181.00
D7963	Frenuloplasty.	$226.00
D7970	Excision of hyperplastic tissue - per arch.	$139.00
D7972	Surgical reduction of fibrous tuberosity.	$222.00
D7980	Sialolithotomy.	$208.00
D7983	Closure of salivary fistula.	$67.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$226.00
D7286	Biopsy of oral tissue - soft.	$122.00
D7287	Exfoliative cytological sample collection.	$61.00
D7288	Brush biopsy - transepithelial sample collection.	$61.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$42.00

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$160.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$52.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$106.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$26.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$42.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$29.00
D9440	Office visit - after regularly scheduled hours.	$52.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$32.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$40.00
D9952	Occlusal adjustment - complete.	$201.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$35.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$19.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$61.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$191.00
D2520	Inlay - metallic - two surfaces.	$227.00
D2530	Inlay - metallic - three or more surfaces.	$244.00
D2610	Inlay - porcelain/ceramic - one surface.	$210.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$229.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$250.00
D2650	Inlay - resin-based composite - one surface.	$218.00
D2651	Inlay - resin-based composite - two surfaces.	$215.00
D2652	Inlay - resin-based composite - three or more surfaces.	$223.00

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

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

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$247.00
D2543	Onlay - metallic - three surfaces.	$276.00
D2544	Onlay - metallic - four or more surfaces.	$287.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$247.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$277.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$285.00
D2662	Onlay - resin-based composite - two surfaces.	$232.00
D2663	Onlay - resin-based composite - three surfaces.	$239.00
D2664	Onlay - resin-based composite - four or more surfaces.	$254.00

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

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

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$108.00
D2712	Crown - 3/4 resin-based composite (indirect).	$268.00
D2720	Crown - resin with high noble metal.	$276.00
D2721	Crown - resin with predominantly base metal.	$210.00
D2722	Crown - resin with noble metal.	$258.00
D2740	Crown - porcelain/ceramic substrate.	$298.00
D2750	Crown - porcelain fused to high noble metal.	$289.00
D2751	Crown - porcelain fused to predominantly base metal.	$248.00
D2752	Crown - porcelain fused to noble metal.	$266.00
D2780	Crown - 3/4 cast high noble metal.	$275.00
D2781	Crown - 3/4 cast predominantly base metal.	$239.00
D2782	Crown - 3/4 cast noble metal.	$250.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$298.00
D2790	Crown - full cast high noble metal.	$275.00
D2791	Crown - full cast predominantly base metal.	$239.00
D2792	Crown - full cast noble metal.	$250.00
D2794	Crown - titanium.	$275.00

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

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

CORE BUILD-UP

D2950	Core buildup, including any pins.	$60.00
D6973	Core build up for retainer, including any pins.	$60.00

CORE BUILDUP: D2950, D6973

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

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$95.00
D2954	Prefabricated post and core in addition to crown.	$79.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$48.00
D6980	Fixed partial denture repair, by report.	$54.00
D9120	Fixed partial denture sectioning.	$54.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$38.00
D3221	Pulpal debridement, primary and permanent teeth.	$38.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$57.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$44.00
D3333	Internal root repair of perforation defects.	$62.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$62.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$42.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$123.00
D3430	Retrograde filling - per root.	$49.00
D3450	Root amputation - per root.	$115.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$98.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$173.00
D3320	Endodontic therapy, bicuspid tooth.	$204.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$267.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$102.00
D3346	Retreatment of previous root canal therapy - anterior.	$215.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$248.00
D3348	Retreatment of previous root canal therapy - molar.	$308.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$178.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$205.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$222.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$79.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$113.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$57.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$155.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$78.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$284.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$142.00
D4263	Bone replacement graft - first site in quadrant.	$93.00
D4264	Bone replacement graft - each additional site in quadrant.	$70.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$46.00
D4270	Pedicle soft tissue graft procedure.	$209.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$221.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$258.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$124.00
D4275	Soft tissue allograft.	$221.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$258.00

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

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

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$171.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$58.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$29.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$43.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$308.00
D5120	Complete denture - mandibular.	$299.00
D5130	Immediate denture - maxillary.	$334.00
D5140	Immediate denture - mandibular.	$323.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$222.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$257.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$222.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$257.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$191.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$222.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$257.00
D5810	Interim complete denture (maxillary).	$136.00
D5811	Interim complete denture (mandibular).	$143.00
D5820	Interim partial denture (maxillary).	$120.00
D5821	Interim partial denture (mandibular).	$126.00
D5860	Overdenture - complete, by report.	$308.00
D5861	Overdenture - partial, by report.	$357.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$308.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$357.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$308.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$357.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$17.00
D5411	Adjust complete denture - mandibular.	$16.00
D5421	Adjust partial denture - maxillary.	$18.00
D5422	Adjust partial denture - mandibular.	$17.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$40.00
D5660	Add clasp to existing partial denture.	$46.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$112.00
D5711	Rebase complete mandibular denture.	$119.00
D5720	Rebase maxillary partial denture.	$107.00
D5721	Rebase mandibular partial denture.	$113.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$31.00
D5851	Tissue conditioning, mandibular.	$34.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$257.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$280.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$280.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$257.00
D6062	Abutment supported cast metal crown (high noble metal).	$280.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$280.00
D6064	Abutment supported cast metal crown (noble metal).	$304.00
D6065	Implant supported porcelain/ceramic crown.	$257.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$257.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$280.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$280.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$257.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$280.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$280.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$304.00
D6075	Implant supported retainer for ceramic FPD.	$257.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$280.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$280.00
D6094	Abutment supported crown - (titanium).	$280.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$280.00
D6205	Pontic - indirect resin based composite.	$231.00
D6210	Pontic - cast high noble metal.	$280.00
D6211	Pontic - cast predominantly base metal.	$280.00
D6212	Pontic - cast noble metal.	$304.00
D6214	Pontic - titanium.	$280.00
D6240	Pontic - porcelain fused to high noble metal.	$280.00
D6241	Pontic - porcelain fused to predominantly base metal.	$280.00
D6242	Pontic - porcelain fused to noble metal.	$257.00
D6245	Pontic - porcelain/ceramic.	$257.00
D6250	Pontic - resin with high noble metal.	$280.00
D6251	Pontic - resin with predominantly base metal.	$257.00
D6252	Pontic - resin with noble metal.	$304.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$93.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$93.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$229.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$251.00
D6602	Inlay - cast high noble metal, two surfaces.	$206.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$226.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$178.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$195.00
D6606	Inlay - cast noble metal, two surfaces.	$187.00
D6607	Inlay - cast noble metal, three or more surfaces.	$206.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$247.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$272.00
D6610	Onlay - cast high noble metal, two surfaces.	$226.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$249.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$195.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$215.00
D6614	Onlay - cast noble metal, two surfaces.	$206.00
D6615	Onlay - cast noble metal, three or more surfaces.	$226.00
D6624	Inlay - titanium.	$226.00
D6634	Onlay - titanium.	$249.00
D6710	Crown - indirect resin based composite.	$231.00
D6720	Crown - resin with high noble metal.	$280.00
D6721	Crown - resin with predominantly base metal.	$145.00
D6722	Crown - resin with noble metal.	$234.00
D6740	Crown - porcelain/ceramic.	$257.00
D6750	Crown - porcelain fused to high noble metal.	$304.00
D6751	Crown - porcelain fused to predominantly base metal.	$280.00
D6752	Crown - porcelain fused to noble metal.	$257.00
D6780	Crown - 3/4 cast high noble metal.	$304.00
D6781	Crown - 3/4 cast predominantly base metal.	$280.00
D6782	Crown - 3/4 cast noble metal.	$257.00
D6783	Crown - 3/4 porcelain/ceramic.	$257.00
D6790	Crown - full cast high noble metal.	$280.00
D6791	Crown - full cast predominantly base metal.	$280.00
D6792	Crown - full cast noble metal.	$257.00
D6794	Crown - titanium.	$280.00
D6940	Stress breaker.	$78.00

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

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

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

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

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

TYPE 3 PROCEDURES

Maximum Covered Expense

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

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

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

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

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

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

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

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$84.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$84.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$45.00
D9973	External bleaching - per tooth.	$28.00
D9974	Internal bleaching - per tooth.	$34.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 4

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

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$23.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$18.00
D0150	Comprehensive oral evaluation - new or established patient.	$36.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$36.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s).
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$76.00
D0330	Panoramic film.	$61.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

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

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$14.00
D0230	Intraoral - periapical each additional film.	$11.00
D0240	Intraoral - occlusal film.	$19.00
D0250	Extraoral - first film.	$24.00
D0260	Extraoral - each additional film.	$19.00

PERIAPICAL FILMS: D0220, D0230

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

BITEWING FILMS		
D0270	Bitewing - single film.	$12.00
D0272	Bitewings - two films.	$21.00
D0273	Bitewings - three films.	$26.00
D0274	Bitewings - four films.	$33.00
D0277	Vertical bitewings - 7 to 8 films.	$50.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$50.00

TYPE 1 PROCEDURES

		Maximum Covered Expense
D1120	Prophylaxis - child.	$35.00
D1203	Topical application of fluoride - child.	$19.00
D1204	Topical application of fluoride - adult.	$19.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$19.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Benefits are considered for persons age 13 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

TYPE 2 PROCEDURES

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

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$29.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$29.00

LIMITED ORAL EVALUATION: D0140, D0170

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

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$35.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$69.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$69.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

SEALANT		
D1351	Sealant - per tooth.	$22.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 13 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$50.00
D2150	Amalgam - two surfaces, primary or permanent.	$63.00
D2160	Amalgam - three surfaces, primary or permanent.	$77.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$92.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$61.00
D2331	Resin-based composite - two surfaces, anterior.	$77.00
D2332	Resin-based composite - three surfaces, anterior.	$96.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$106.00
D2391	Resin-based composite - one surface, posterior.	$67.00
D2392	Resin-based composite - two surfaces, posterior.	$84.00
D2393	Resin-based composite - three surfaces, posterior.	$106.00
D2394	Resin-based composite - four or more surfaces, posterior.	$117.00
D2410	Gold foil - one surface.	$50.00
D2420	Gold foil - two surfaces.	$63.00
D2430	Gold foil - three surfaces.	$77.00

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 2 PROCEDURES

		Maximum Covered Expense

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$129.00
D2930	Prefabricated stainless steel crown - primary tooth.	$108.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$115.00
D2932	Prefabricated resin crown.	$129.00
D2933	Prefabricated stainless steel crown with resin window.	$129.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$129.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$40.00
D2915	Recement cast or prefabricated post and core.	$20.00
D2920	Recement crown.	$39.00
D6092	Recement implant/abutment supported crown.	$39.00
D6093	Recement implant/abutment supported fixed partial denture.	$39.00
D6930	Recement fixed partial denture.	$54.00

SEDATIVE FILLING

D2940	Sedative filling.	$37.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$67.00
D3221	Pulpal debridement, primary and permanent teeth.	$67.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$102.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$90.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$78.00
D3333	Internal root repair of perforation defects.	$111.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$111.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$75.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$219.00
D3430	Retrograde filling - per root.	$87.00
D3450	Root amputation - per root.	$206.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$174.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$308.00
D3320	Endodontic therapy, bicuspid tooth.	$363.00
D3330	Endodontic therapy, molar.	$476.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$182.00
D3346	Retreatment of previous root canal therapy - anterior.	$384.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$442.00
D3348	Retreatment of previous root canal therapy - molar.	$549.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.

TYPE 2 PROCEDURES

- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

FULL MOUTH DEBRIDEMENT

		Maximum Covered Expense
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$62.00

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$63.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$63.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$52.00
D5610	Repair resin denture base.	$62.00
D5620	Repair cast framework.	$74.00
D5630	Repair or replace broken clasp.	$77.00
D5640	Replace broken teeth - per tooth.	$56.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$117.00
D5731	Reline complete mandibular denture (chairside).	$116.00
D5740	Reline maxillary partial denture (chairside).	$104.00
D5741	Reline mandibular partial denture (chairside).	$105.00
D5750	Reline complete maxillary denture (laboratory).	$173.00
D5751	Reline complete mandibular denture (laboratory).	$170.00
D5760	Reline maxillary partial denture (laboratory).	$173.00
D5761	Reline mandibular partial denture (laboratory).	$174.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$56.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$56.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$263.00
D7261	Primary closure of a sinus perforation.	$263.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$159.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$159.00
D7280	Surgical access of an unerupted tooth.	$247.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$177.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$74.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$92.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$47.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$117.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$59.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$170.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$422.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7410	Excision of benign lesion up to 1.25 cm.	$168.00
D7411	Excision of benign lesion greater than 1.25 cm.	$216.00
D7412	Excision of benign lesion, complicated.	$237.00
D7413	Excision of malignant lesion up to 1.25 cm.	$227.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$167.00
D7415	Excision of malignant lesion, complicated.	$183.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$227.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$167.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$51.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$150.00
D7472	Removal of torus palatinus.	$150.00
D7473	Removal of torus mandibularis.	$150.00
D7485	Surgical reduction of osseous tuberosity.	$244.00
D7490	Radical resection of maxilla or mandible.	$227.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$75.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$87.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$69.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$190.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$190.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$250.00
D7910	Suture of recent small wounds up to 5 cm.	$33.00
D7911	Complicated suture - up to 5 cm.	$37.00
D7912	Complicated suture - greater than 5 cm.	$54.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$181.00
D7963	Frenuloplasty.	$226.00
D7970	Excision of hyperplastic tissue - per arch.	$139.00
D7972	Surgical reduction of fibrous tuberosity.	$222.00
D7980	Sialolithotomy.	$208.00
D7983	Closure of salivary fistula.	$67.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$226.00
D7286	Biopsy of oral tissue - soft.	$122.00
D7287	Exfoliative cytological sample collection.	$61.00
D7288	Brush biopsy - transepithelial sample collection.	$61.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$42.00

PALLIATIVE TREATMENT: D9110

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

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$42.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$29.00
D9440	Office visit - after regularly scheduled hours.	$52.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$32.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

TYPE 2 PROCEDURES

		Maximum Covered Expense
OCCLUSAL ADJUSTMENT		
D9951	Occlusal adjustment - limited.	$40.00
D9952	Occlusal adjustment - complete.	$201.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS		
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$35.00
D2951	Pin retention - per tooth, in addition to restoration.	$19.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$61.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

Class Number 5

TYPE 1 PROCEDURES

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

ROUTINE ORAL EVALUATION		Maximum Covered Expense
D0120	Periodic oral evaluation - established patient.	$33.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$25.00
D0150	Comprehensive oral evaluation - new or established patient.	$50.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$50.00

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

BITEWING FILMS		
D0270	Bitewing - single film.	$16.00
D0272	Bitewings - two films.	$30.00
D0273	Bitewings - three films.	$36.00
D0274	Bitewings - four films.	$46.00
D0277	Vertical bitewings - 7 to 8 films.	$70.00

BITEWING FILMS: D0270, D0272, D0273, D0274

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

VERTICAL BITEWING FILM: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$70.00
D1120	Prophylaxis - child.	$49.00
D1203	Topical application of fluoride - child.	$27.00
D1204	Topical application of fluoride - adult.	$27.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$27.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$38.00

SEALANT: D1351

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

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$246.00
D1515	Space maintainer - fixed - bilateral.	$402.00
D1520	Space maintainer - removable - unilateral.	$385.00
D1525	Space maintainer - removable - bilateral.	$469.00
D1550	Re-cementation of space maintainer.	$50.00
D1555	Removal of fixed space maintainer.	$70.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$370.00
D8220	Fixed appliance therapy.	$370.00

APPLIANCE THERAPY: D8210, D8220

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

TYPE 2 PROCEDURES

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

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$41.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$41.00

LIMITED ORAL EVALUATION: D0140, D0170

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

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$83.00
D0330	Panoramic film.	$67.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

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

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$15.00
D0230	Intraoral - periapical each additional film.	$12.00
D0240	Intraoral - occlusal film.	$21.00
D0250	Extraoral - first film.	$27.00
D0260	Extraoral - each additional film.	$21.00

PERIAPICAL FILMS: D0220, D0230

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

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$49.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$97.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$97.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$70.00
D2150	Amalgam - two surfaces, primary or permanent.	$89.00
D2160	Amalgam - three surfaces, primary or permanent.	$107.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$128.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$85.00
D2331	Resin-based composite - two surfaces, anterior.	$107.00
D2332	Resin-based composite - three surfaces, anterior.	$134.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$148.00
D2391	Resin-based composite - one surface, posterior.	$93.00
D2392	Resin-based composite - two surfaces, posterior.	$118.00
D2393	Resin-based composite - three surfaces, posterior.	$148.00
D2394	Resin-based composite - four or more surfaces, posterior.	$163.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$70.00
D2420	Gold foil - two surfaces.	$89.00
D2430	Gold foil - three surfaces.	$107.00

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$181.00
D2930	Prefabricated stainless steel crown - primary tooth.	$152.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$161.00
D2932	Prefabricated resin crown.	$181.00
D2933	Prefabricated stainless steel crown with resin window.	$181.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$181.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$56.00
D2915	Recement cast or prefabricated post and core.	$28.00
D2920	Recement crown.	$55.00
D6092	Recement implant/abutment supported crown.	$55.00
D6093	Recement implant/abutment supported fixed partial denture.	$55.00
D6930	Recement fixed partial denture.	$76.00

SEDATIVE FILLING

D2940	Sedative filling.	$51.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$86.00

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$89.00

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	$89.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$74.00
D5610	Repair resin denture base.	$88.00
D5620	Repair cast framework.	$104.00
D5630	Repair or replace broken clasp.	$109.00
D5640	Replace broken teeth - per tooth.	$78.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$163.00
D5731	Reline complete mandibular denture (chairside).	$162.00
D5740	Reline maxillary partial denture (chairside).	$146.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$147.00
D5750	Reline complete maxillary denture (laboratory).	$243.00
D5751	Reline complete mandibular denture (laboratory).	$238.00
D5760	Reline maxillary partial denture (laboratory).	$243.00
D5761	Reline mandibular partial denture (laboratory).	$244.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$78.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$78.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$151.00
D7220	Removal of impacted tooth - soft tissue.	$188.00
D7230	Removal of impacted tooth - partially bony.	$250.00
D7240	Removal of impacted tooth - completely bony.	$292.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$333.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$156.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$369.00
D7261	Primary closure of a sinus perforation.	$369.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$223.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$223.00
D7280	Surgical access of an unerupted tooth.	$345.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$249.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$104.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$130.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$65.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$165.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$83.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$238.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$592.00
D7410	Excision of benign lesion up to 1.25 cm.	$236.00
D7411	Excision of benign lesion greater than 1.25 cm.	$302.00
D7412	Excision of benign lesion, complicated.	$333.00
D7413	Excision of malignant lesion up to 1.25 cm.	$319.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$233.00
D7415	Excision of malignant lesion, complicated.	$257.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$319.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$233.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$71.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$210.00
D7472	Removal of torus palatinus.	$210.00
D7473	Removal of torus mandibularis.	$210.00
D7485	Surgical reduction of osseous tuberosity.	$342.00
D7490	Radical resection of maxilla or mandible.	$319.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$105.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$121.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$97.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$266.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$266.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$350.00
D7910	Suture of recent small wounds up to 5 cm.	$47.00
D7911	Complicated suture - up to 5 cm.	$53.00
D7912	Complicated suture - greater than 5 cm.	$76.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$253.00
D7963	Frenuloplasty.	$316.00
D7970	Excision of hyperplastic tissue - per arch.	$195.00
D7972	Surgical reduction of fibrous tuberosity.	$310.00
D7980	Sialolithotomy.	$292.00
D7983	Closure of salivary fistula.	$93.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$316.00
D7286	Biopsy of oral tissue - soft.	$170.00
D7287	Exfoliative cytological sample collection.	$85.00
D7288	Brush biopsy - transepithelial sample collection.	$85.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$58.00

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$224.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$74.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$148.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$36.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$60.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$41.00
D9440	Office visit - after regularly scheduled hours.	$72.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$44.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$56.00
D9952	Occlusal adjustment - complete.	$281.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$49.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$27.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$85.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$305.00
D2520	Inlay - metallic - two surfaces.	$363.00
D2530	Inlay - metallic - three or more surfaces.	$391.00
D2610	Inlay - porcelain/ceramic - one surface.	$336.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$366.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$401.00
D2650	Inlay - resin-based composite - one surface.	$349.00
D2651	Inlay - resin-based composite - two surfaces.	$345.00
D2652	Inlay - resin-based composite - three or more surfaces.	$357.00

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

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

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$396.00
D2543	Onlay - metallic - three surfaces.	$441.00
D2544	Onlay - metallic - four or more surfaces.	$459.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$396.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$443.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$456.00
D2662	Onlay - resin-based composite - two surfaces.	$371.00
D2663	Onlay - resin-based composite - three surfaces.	$382.00
D2664	Onlay - resin-based composite - four or more surfaces.	$406.00

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

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

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$173.00
D2712	Crown - 3/4 resin-based composite (indirect).	$428.00
D2720	Crown - resin with high noble metal.	$441.00
D2721	Crown - resin with predominantly base metal.	$336.00
D2722	Crown - resin with noble metal.	$413.00
D2740	Crown - porcelain/ceramic substrate.	$476.00
D2750	Crown - porcelain fused to high noble metal.	$463.00
D2751	Crown - porcelain fused to predominantly base metal.	$397.00
D2752	Crown - porcelain fused to noble metal.	$425.00
D2780	Crown - 3/4 cast high noble metal.	$440.00
D2781	Crown - 3/4 cast predominantly base metal.	$383.00
D2782	Crown - 3/4 cast noble metal.	$400.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$476.00
D2790	Crown - full cast high noble metal.	$440.00
D2791	Crown - full cast predominantly base metal.	$383.00
D2792	Crown - full cast noble metal.	$400.00
D2794	Crown - titanium.	$440.00

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

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

CORE BUILD-UP

D2950	Core buildup, including any pins.	$96.00
D6973	Core build up for retainer, including any pins.	$96.00

CORE BUILDUP: D2950, D6973

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

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$153.00
D2954	Prefabricated post and core in addition to crown.	$127.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$77.00
D6980	Fixed partial denture repair, by report.	$86.00
D9120	Fixed partial denture sectioning.	$86.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$61.00
D3221	Pulpal debridement, primary and permanent teeth.	$61.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$91.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$81.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$70.00
D3333	Internal root repair of perforation defects.	$99.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$99.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$67.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$197.00
D3430	Retrograde filling - per root.	$78.00
D3450	Root amputation - per root.	$185.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$156.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$277.00
D3320	Endodontic therapy, bicuspid tooth.	$326.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$427.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$163.00
D3346	Retreatment of previous root canal therapy - anterior.	$345.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$397.00
D3348	Retreatment of previous root canal therapy - molar.	$493.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$285.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$328.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$355.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$127.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$180.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$90.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$247.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$124.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$454.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$227.00
D4263	Bone replacement graft - first site in quadrant.	$148.00
D4264	Bone replacement graft - each additional site in quadrant.	$111.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$74.00
D4270	Pedicle soft tissue graft procedure.	$334.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$354.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$413.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$199.00
D4275	Soft tissue allograft.	$354.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$413.00

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

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

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$273.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$93.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$46.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$68.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$493.00
D5120	Complete denture - mandibular.	$478.00
D5130	Immediate denture - maxillary.	$534.00
D5140	Immediate denture - mandibular.	$517.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$354.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$410.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$354.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$410.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$306.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$354.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$410.00
D5810	Interim complete denture (maxillary).	$218.00
D5811	Interim complete denture (mandibular).	$230.00
D5820	Interim partial denture (maxillary).	$191.00
D5821	Interim partial denture (mandibular).	$201.00
D5860	Overdenture - complete, by report.	$493.00
D5861	Overdenture - partial, by report.	$571.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$493.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$571.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$493.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$571.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$28.00
D5411	Adjust complete denture - mandibular.	$26.00
D5421	Adjust partial denture - maxillary.	$29.00
D5422	Adjust partial denture - mandibular.	$28.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$64.00
D5660	Add clasp to existing partial denture.	$74.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$179.00
D5711	Rebase complete mandibular denture.	$190.00
D5720	Rebase maxillary partial denture.	$171.00
D5721	Rebase mandibular partial denture.	$181.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$50.00
D5851	Tissue conditioning, mandibular.	$54.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$411.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$449.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$449.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$411.00
D6062	Abutment supported cast metal crown (high noble metal).	$449.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$449.00
D6064	Abutment supported cast metal crown (noble metal).	$486.00
D6065	Implant supported porcelain/ceramic crown.	$411.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$411.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$449.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$449.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$411.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$449.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$449.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$486.00
D6075	Implant supported retainer for ceramic FPD.	$411.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$449.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$449.00
D6094	Abutment supported crown - (titanium).	$449.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$449.00
D6205	Pontic - indirect resin based composite.	$370.00
D6210	Pontic - cast high noble metal.	$449.00
D6211	Pontic - cast predominantly base metal.	$449.00
D6212	Pontic - cast noble metal.	$486.00
D6214	Pontic - titanium.	$449.00
D6240	Pontic - porcelain fused to high noble metal.	$449.00
D6241	Pontic - porcelain fused to predominantly base metal.	$449.00
D6242	Pontic - porcelain fused to noble metal.	$411.00
D6245	Pontic - porcelain/ceramic.	$411.00
D6250	Pontic - resin with high noble metal.	$449.00
D6251	Pontic - resin with predominantly base metal.	$411.00
D6252	Pontic - resin with noble metal.	$486.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$150.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$150.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$366.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$402.00
D6602	Inlay - cast high noble metal, two surfaces.	$329.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$362.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$284.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$313.00
D6606	Inlay - cast noble metal, two surfaces.	$299.00
D6607	Inlay - cast noble metal, three or more surfaces.	$329.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$396.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$435.00
D6610	Onlay - cast high noble metal, two surfaces.	$362.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$398.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$313.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$344.00
D6614	Onlay - cast noble metal, two surfaces.	$329.00
D6615	Onlay - cast noble metal, three or more surfaces.	$362.00
D6624	Inlay - titanium.	$362.00
D6634	Onlay - titanium.	$398.00
D6710	Crown - indirect resin based composite.	$370.00
D6720	Crown - resin with high noble metal.	$449.00
D6721	Crown - resin with predominantly base metal.	$233.00
D6722	Crown - resin with noble metal.	$374.00
D6740	Crown - porcelain/ceramic.	$411.00
D6750	Crown - porcelain fused to high noble metal.	$486.00
D6751	Crown - porcelain fused to predominantly base metal.	$449.00
D6752	Crown - porcelain fused to noble metal.	$411.00
D6780	Crown - 3/4 cast high noble metal.	$486.00
D6781	Crown - 3/4 cast predominantly base metal.	$449.00
D6782	Crown - 3/4 cast noble metal.	$411.00
D6783	Crown - 3/4 porcelain/ceramic.	$411.00
D6790	Crown - full cast high noble metal.	$449.00
D6791	Crown - full cast predominantly base metal.	$449.00
D6792	Crown - full cast noble metal.	$411.00
D6794	Crown - titanium.	$449.00
D6940	Stress breaker.	$124.00

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

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

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

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

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

TYPE 3 PROCEDURES

Maximum Covered Expense

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

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

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

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

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

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

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

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$135.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$135.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$72.00
D9973	External bleaching - per tooth.	$45.00
D9974	Internal bleaching - per tooth.	$54.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 6

TYPE 1 PROCEDURES

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

ROUTINE ORAL EVALUATION		Maximum Covered Expense
D0120	Periodic oral evaluation - established patient.	$28.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$22.00
D0150	Comprehensive oral evaluation - new or established patient.	$43.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$43.00

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

BITEWING FILMS		
D0270	Bitewing - single film.	$14.00
D0272	Bitewings - two films.	$26.00
D0273	Bitewings - three films.	$31.00
D0274	Bitewings - four films.	$40.00
D0277	Vertical bitewings - 7 to 8 films.	$60.00

BITEWING FILMS: D0270, D0272, D0273, D0274

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

VERTICAL BITEWING FILM: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$60.00
D1120	Prophylaxis - child.	$42.00
D1203	Topical application of fluoride - child.	$23.00
D1204	Topical application of fluoride - adult.	$23.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$23.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$33.00

SEALANT: D1351

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

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$212.00
D1515	Space maintainer - fixed - bilateral.	$347.00
D1520	Space maintainer - removable - unilateral.	$332.00
D1525	Space maintainer - removable - bilateral.	$405.00
D1550	Re-cementation of space maintainer.	$43.00
D1555	Removal of fixed space maintainer.	$60.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$319.00
D8220	Fixed appliance therapy.	$319.00

APPLIANCE THERAPY: D8210, D8220

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

TYPE 2 PROCEDURES

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

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$35.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$35.00

LIMITED ORAL EVALUATION: D0140, D0170

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

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$71.00
D0330	Panoramic film.	$57.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

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

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$13.00
D0230	Intraoral - periapical each additional film.	$10.00
D0240	Intraoral - occlusal film.	$18.00
D0250	Extraoral - first film.	$23.00
D0260	Extraoral - each additional film.	$18.00

PERIAPICAL FILMS: D0220, D0230

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

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$42.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$83.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$83.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$60.00
D2150	Amalgam - two surfaces, primary or permanent.	$76.00
D2160	Amalgam - three surfaces, primary or permanent.	$92.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$110.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$73.00
D2331	Resin-based composite - two surfaces, anterior.	$92.00
D2332	Resin-based composite - three surfaces, anterior.	$115.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$127.00
D2391	Resin-based composite - one surface, posterior.	$80.00
D2392	Resin-based composite - two surfaces, posterior.	$101.00
D2393	Resin-based composite - three surfaces, posterior.	$127.00
D2394	Resin-based composite - four or more surfaces, posterior.	$140.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$60.00
D2420	Gold foil - two surfaces.	$76.00
D2430	Gold foil - three surfaces.	$92.00

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$155.00
D2930	Prefabricated stainless steel crown - primary tooth.	$130.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$138.00
D2932	Prefabricated resin crown.	$155.00
D2933	Prefabricated stainless steel crown with resin window.	$155.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$155.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$48.00
D2915	Recement cast or prefabricated post and core.	$24.00
D2920	Recement crown.	$47.00
D6092	Recement implant/abutment supported crown.	$47.00
D6093	Recement implant/abutment supported fixed partial denture.	$47.00
D6930	Recement fixed partial denture.	$65.00

SEDATIVE FILLING

D2940	Sedative filling.	$44.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$74.00

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$76.00

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	$76.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$63.00
D5610	Repair resin denture base.	$75.00
D5620	Repair cast framework.	$89.00
D5630	Repair or replace broken clasp.	$93.00
D5640	Replace broken teeth - per tooth.	$67.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$140.00
D5731	Reline complete mandibular denture (chairside).	$139.00
D5740	Reline maxillary partial denture (chairside).	$125.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$126.00
D5750	Reline complete maxillary denture (laboratory).	$208.00
D5751	Reline complete mandibular denture (laboratory).	$204.00
D5760	Reline maxillary partial denture (laboratory).	$208.00
D5761	Reline mandibular partial denture (laboratory).	$209.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$67.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$67.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$129.00
D7220	Removal of impacted tooth - soft tissue.	$161.00
D7230	Removal of impacted tooth - partially bony.	$214.00
D7240	Removal of impacted tooth - completely bony.	$250.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$285.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$134.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$316.00
D7261	Primary closure of a sinus perforation.	$316.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$191.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$191.00
D7280	Surgical access of an unerupted tooth.	$296.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$213.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$89.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$111.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$56.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$141.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$71.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$204.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$507.00
D7410	Excision of benign lesion up to 1.25 cm.	$202.00
D7411	Excision of benign lesion greater than 1.25 cm.	$259.00
D7412	Excision of benign lesion, complicated.	$285.00
D7413	Excision of malignant lesion up to 1.25 cm.	$273.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$200.00
D7415	Excision of malignant lesion, complicated.	$220.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$273.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$200.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$61.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$180.00
D7472	Removal of torus palatinus.	$180.00
D7473	Removal of torus mandibularis.	$180.00
D7485	Surgical reduction of osseous tuberosity.	$293.00
D7490	Radical resection of maxilla or mandible.	$273.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$90.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$104.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$83.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$228.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$228.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$300.00
D7910	Suture of recent small wounds up to 5 cm.	$40.00
D7911	Complicated suture - up to 5 cm.	$45.00
D7912	Complicated suture - greater than 5 cm.	$65.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$217.00
D7963	Frenuloplasty.	$271.00
D7970	Excision of hyperplastic tissue - per arch.	$167.00
D7972	Surgical reduction of fibrous tuberosity.	$266.00
D7980	Sialolithotomy.	$250.00
D7983	Closure of salivary fistula.	$80.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$271.00
D7286	Biopsy of oral tissue - soft.	$146.00
D7287	Exfoliative cytological sample collection.	$73.00
D7288	Brush biopsy - transepithelial sample collection.	$73.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$50.00

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$192.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$63.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$127.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$31.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$51.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$35.00
D9440	Office visit - after regularly scheduled hours.	$62.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$38.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$48.00
D9952	Occlusal adjustment - complete.	$241.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$42.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$23.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$73.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$248.00
D2520	Inlay - metallic - two surfaces.	$295.00
D2530	Inlay - metallic - three or more surfaces.	$318.00
D2610	Inlay - porcelain/ceramic - one surface.	$273.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$297.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$326.00
D2650	Inlay - resin-based composite - one surface.	$284.00
D2651	Inlay - resin-based composite - two surfaces.	$280.00
D2652	Inlay - resin-based composite - three or more surfaces.	$290.00

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

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

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$321.00
D2543	Onlay - metallic - three surfaces.	$358.00
D2544	Onlay - metallic - four or more surfaces.	$373.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$321.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$360.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$371.00
D2662	Onlay - resin-based composite - two surfaces.	$301.00
D2663	Onlay - resin-based composite - three surfaces.	$310.00
D2664	Onlay - resin-based composite - four or more surfaces.	$330.00

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

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

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$140.00
D2712	Crown - 3/4 resin-based composite (indirect).	$348.00
D2720	Crown - resin with high noble metal.	$358.00
D2721	Crown - resin with predominantly base metal.	$273.00
D2722	Crown - resin with noble metal.	$335.00
D2740	Crown - porcelain/ceramic substrate.	$387.00
D2750	Crown - porcelain fused to high noble metal.	$376.00
D2751	Crown - porcelain fused to predominantly base metal.	$323.00
D2752	Crown - porcelain fused to noble metal.	$346.00
D2780	Crown - 3/4 cast high noble metal.	$358.00
D2781	Crown - 3/4 cast predominantly base metal.	$311.00
D2782	Crown - 3/4 cast noble metal.	$325.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$387.00
D2790	Crown - full cast high noble metal.	$358.00
D2791	Crown - full cast predominantly base metal.	$311.00
D2792	Crown - full cast noble metal.	$325.00
D2794	Crown - titanium.	$358.00

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

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

CORE BUILD-UP

D2950	Core buildup, including any pins.	$78.00
D6973	Core build up for retainer, including any pins.	$78.00

CORE BUILDUP: D2950, D6973

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

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$124.00
D2954	Prefabricated post and core in addition to crown.	$103.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$63.00
D6980	Fixed partial denture repair, by report.	$70.00
D9120	Fixed partial denture sectioning.	$70.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$49.00
D3221	Pulpal debridement, primary and permanent teeth.	$49.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$74.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$66.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$57.00
D3333	Internal root repair of perforation defects.	$81.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$81.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$55.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$160.00
D3430	Retrograde filling - per root.	$63.00
D3450	Root amputation - per root.	$150.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$127.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$225.00
D3320	Endodontic therapy, bicuspid tooth.	$265.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$347.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$132.00
D3346	Retreatment of previous root canal therapy - anterior.	$280.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$323.00
D3348	Retreatment of previous root canal therapy - molar.	$400.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$231.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$267.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$289.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$103.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$146.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$74.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$201.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$101.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$369.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$185.00
D4263	Bone replacement graft - first site in quadrant.	$120.00
D4264	Bone replacement graft - each additional site in quadrant.	$91.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$60.00
D4270	Pedicle soft tissue graft procedure.	$272.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$287.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$335.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$162.00
D4275	Soft tissue allograft.	$287.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$335.00

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

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

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$222.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$75.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$38.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$55.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$400.00
D5120	Complete denture - mandibular.	$388.00
D5130	Immediate denture - maxillary.	$434.00
D5140	Immediate denture - mandibular.	$420.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$288.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$334.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$288.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$334.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$248.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$288.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$334.00
D5810	Interim complete denture (maxillary).	$177.00
D5811	Interim complete denture (mandibular).	$187.00
D5820	Interim partial denture (maxillary).	$156.00
D5821	Interim partial denture (mandibular).	$163.00
D5860	Overdenture - complete, by report.	$400.00
D5861	Overdenture - partial, by report.	$464.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$400.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$464.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$400.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$464.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$22.00
D5411	Adjust complete denture - mandibular.	$21.00
D5421	Adjust partial denture - maxillary.	$24.00
D5422	Adjust partial denture - mandibular.	$22.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$52.00
D5660	Add clasp to existing partial denture.	$60.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$146.00
D5711	Rebase complete mandibular denture.	$154.00
D5720	Rebase maxillary partial denture.	$139.00
D5721	Rebase mandibular partial denture.	$147.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$41.00
D5851	Tissue conditioning, mandibular.	$44.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$334.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$365.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$365.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$334.00
D6062	Abutment supported cast metal crown (high noble metal).	$365.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$365.00
D6064	Abutment supported cast metal crown (noble metal).	$395.00
D6065	Implant supported porcelain/ceramic crown.	$334.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$334.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$365.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$365.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$334.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$365.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$365.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$395.00
D6075	Implant supported retainer for ceramic FPD.	$334.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$365.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$365.00
D6094	Abutment supported crown - (titanium).	$365.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$365.00
D6205	Pontic - indirect resin based composite.	$301.00
D6210	Pontic - cast high noble metal.	$365.00
D6211	Pontic - cast predominantly base metal.	$365.00
D6212	Pontic - cast noble metal.	$395.00
D6214	Pontic - titanium.	$365.00
D6240	Pontic - porcelain fused to high noble metal.	$365.00
D6241	Pontic - porcelain fused to predominantly base metal.	$365.00
D6242	Pontic - porcelain fused to noble metal.	$334.00
D6245	Pontic - porcelain/ceramic.	$334.00
D6250	Pontic - resin with high noble metal.	$365.00
D6251	Pontic - resin with predominantly base metal.	$334.00
D6252	Pontic - resin with noble metal.	$395.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$122.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$122.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$297.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$327.00
D6602	Inlay - cast high noble metal, two surfaces.	$267.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$294.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$231.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$254.00
D6606	Inlay - cast noble metal, two surfaces.	$243.00
D6607	Inlay - cast noble metal, three or more surfaces.	$267.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$321.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$354.00
D6610	Onlay - cast high noble metal, two surfaces.	$294.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$323.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$254.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$279.00
D6614	Onlay - cast noble metal, two surfaces.	$267.00
D6615	Onlay - cast noble metal, three or more surfaces.	$294.00
D6624	Inlay - titanium.	$294.00
D6634	Onlay - titanium.	$323.00
D6710	Crown - indirect resin based composite.	$301.00
D6720	Crown - resin with high noble metal.	$365.00
D6721	Crown - resin with predominantly base metal.	$189.00
D6722	Crown - resin with noble metal.	$304.00
D6740	Crown - porcelain/ceramic.	$334.00
D6750	Crown - porcelain fused to high noble metal.	$395.00
D6751	Crown - porcelain fused to predominantly base metal.	$365.00
D6752	Crown - porcelain fused to noble metal.	$334.00
D6780	Crown - 3/4 cast high noble metal.	$395.00
D6781	Crown - 3/4 cast predominantly base metal.	$365.00
D6782	Crown - 3/4 cast noble metal.	$334.00
D6783	Crown - 3/4 porcelain/ceramic.	$334.00
D6790	Crown - full cast high noble metal.	$365.00
D6791	Crown - full cast predominantly base metal.	$365.00
D6792	Crown - full cast noble metal.	$334.00
D6794	Crown - titanium.	$365.00
D6940	Stress breaker.	$101.00

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

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

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

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

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

TYPE 3 PROCEDURES

Maximum Covered Expense

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

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

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

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

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

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

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

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$109.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$109.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$58.00
D9973	External bleaching - per tooth.	$36.00
D9974	Internal bleaching - per tooth.	$44.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 7

TYPE 1 PROCEDURES

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

ROUTINE ORAL EVALUATION		Maximum Covered Expense
D0120	Periodic oral evaluation - established patient.	$23.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$18.00
D0150	Comprehensive oral evaluation - new or established patient.	$36.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$36.00

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120, D0145

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

BITEWING FILMS		
D0270	Bitewing - single film.	$12.00
D0272	Bitewings - two films.	$21.00
D0273	Bitewings - three films.	$26.00
D0274	Bitewings - four films.	$33.00
D0277	Vertical bitewings - 7 to 8 films.	$50.00

BITEWING FILMS: D0270, D0272, D0273, D0274

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

VERTICAL BITEWING FILM: D0277

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

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$50.00
D1120	Prophylaxis - child.	$35.00
D1203	Topical application of fluoride - child.	$19.00
D1204	Topical application of fluoride - adult.	$19.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$19.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$28.00

SEALANT: D1351

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

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$177.00
D1515	Space maintainer - fixed - bilateral.	$289.00
D1520	Space maintainer - removable - unilateral.	$277.00
D1525	Space maintainer - removable - bilateral.	$337.00
D1550	Re-cementation of space maintainer.	$36.00
D1555	Removal of fixed space maintainer.	$50.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

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

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$266.00
D8220	Fixed appliance therapy.	$266.00

APPLIANCE THERAPY: D8210, D8220

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

TYPE 2 PROCEDURES

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

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$29.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$29.00

LIMITED ORAL EVALUATION: D0140, D0170

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

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$59.00
D0330	Panoramic film.	$47.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

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

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$11.00
D0230	Intraoral - periapical each additional film.	$8.00
D0240	Intraoral - occlusal film.	$15.00
D0250	Extraoral - first film.	$19.00
D0260	Extraoral - each additional film.	$15.00

PERIAPICAL FILMS: D0220, D0230

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

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$35.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$69.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$69.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

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

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$50.00
D2150	Amalgam - two surfaces, primary or permanent.	$63.00
D2160	Amalgam - three surfaces, primary or permanent.	$77.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$92.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

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

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$61.00
D2331	Resin-based composite - two surfaces, anterior.	$77.00
D2332	Resin-based composite - three surfaces, anterior.	$96.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$106.00
D2391	Resin-based composite - one surface, posterior.	$67.00
D2392	Resin-based composite - two surfaces, posterior.	$84.00
D2393	Resin-based composite - three surfaces, posterior.	$106.00
D2394	Resin-based composite - four or more surfaces, posterior.	$117.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$50.00
D2420	Gold foil - two surfaces.	$63.00
D2430	Gold foil - three surfaces.	$77.00

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

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$129.00
D2930	Prefabricated stainless steel crown - primary tooth.	$108.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$115.00
D2932	Prefabricated resin crown.	$129.00
D2933	Prefabricated stainless steel crown with resin window.	$129.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$129.00

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

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

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$40.00
D2915	Recement cast or prefabricated post and core.	$20.00
D2920	Recement crown.	$39.00
D6092	Recement implant/abutment supported crown.	$39.00
D6093	Recement implant/abutment supported fixed partial denture.	$39.00
D6930	Recement fixed partial denture.	$54.00

SEDATIVE FILLING

D2940	Sedative filling.	$37.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$62.00

FULL MOUTH DEBRIDEMENT: D4355

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

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$63.00

PERIODONTAL MAINTENANCE: D4910

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	$63.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$52.00
D5610	Repair resin denture base.	$62.00
D5620	Repair cast framework.	$74.00
D5630	Repair or replace broken clasp.	$77.00
D5640	Replace broken teeth - per tooth.	$56.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$117.00
D5731	Reline complete mandibular denture (chairside).	$116.00
D5740	Reline maxillary partial denture (chairside).	$104.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$105.00
D5750	Reline complete maxillary denture (laboratory).	$173.00
D5751	Reline complete mandibular denture (laboratory).	$170.00
D5760	Reline maxillary partial denture (laboratory).	$173.00
D5761	Reline mandibular partial denture (laboratory).	$174.00

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

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

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$56.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$56.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$107.00
D7220	Removal of impacted tooth - soft tissue.	$134.00
D7230	Removal of impacted tooth - partially bony.	$178.00
D7240	Removal of impacted tooth - completely bony.	$208.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$237.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$112.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$263.00
D7261	Primary closure of a sinus perforation.	$263.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$159.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$159.00
D7280	Surgical access of an unerupted tooth.	$247.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$177.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$74.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$92.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$47.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$117.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$59.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$170.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$422.00
D7410	Excision of benign lesion up to 1.25 cm.	$168.00
D7411	Excision of benign lesion greater than 1.25 cm.	$216.00
D7412	Excision of benign lesion, complicated.	$237.00
D7413	Excision of malignant lesion up to 1.25 cm.	$227.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$167.00
D7415	Excision of malignant lesion, complicated.	$183.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$227.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$167.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$51.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$150.00
D7472	Removal of torus palatinus.	$150.00
D7473	Removal of torus mandibularis.	$150.00
D7485	Surgical reduction of osseous tuberosity.	$244.00
D7490	Radical resection of maxilla or mandible.	$227.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$75.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$87.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$69.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$190.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$190.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$250.00
D7910	Suture of recent small wounds up to 5 cm.	$33.00
D7911	Complicated suture - up to 5 cm.	$37.00
D7912	Complicated suture - greater than 5 cm.	$54.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$181.00
D7963	Frenuloplasty.	$226.00
D7970	Excision of hyperplastic tissue - per arch.	$139.00
D7972	Surgical reduction of fibrous tuberosity.	$222.00
D7980	Sialolithotomy.	$208.00
D7983	Closure of salivary fistula.	$67.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$226.00
D7286	Biopsy of oral tissue - soft.	$122.00
D7287	Exfoliative cytological sample collection.	$61.00
D7288	Brush biopsy - transepithelial sample collection.	$61.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$42.00

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$160.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$52.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$106.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$26.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$42.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$29.00
D9440	Office visit - after regularly scheduled hours.	$52.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$32.00

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$40.00
D9952	Occlusal adjustment - complete.	$201.00

OCCLUSAL ADJUSTMENT: D9951, D9952

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

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$35.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$19.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$61.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$191.00
D2520	Inlay - metallic - two surfaces.	$227.00
D2530	Inlay - metallic - three or more surfaces.	$244.00
D2610	Inlay - porcelain/ceramic - one surface.	$210.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$229.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$250.00
D2650	Inlay - resin-based composite - one surface.	$218.00
D2651	Inlay - resin-based composite - two surfaces.	$215.00
D2652	Inlay - resin-based composite - three or more surfaces.	$223.00

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

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

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$247.00
D2543	Onlay - metallic - three surfaces.	$276.00
D2544	Onlay - metallic - four or more surfaces.	$287.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$247.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$277.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$285.00
D2662	Onlay - resin-based composite - two surfaces.	$232.00
D2663	Onlay - resin-based composite - three surfaces.	$239.00
D2664	Onlay - resin-based composite - four or more surfaces.	$254.00

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

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

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$108.00
D2712	Crown - 3/4 resin-based composite (indirect).	$268.00
D2720	Crown - resin with high noble metal.	$276.00
D2721	Crown - resin with predominantly base metal.	$210.00
D2722	Crown - resin with noble metal.	$258.00
D2740	Crown - porcelain/ceramic substrate.	$298.00
D2750	Crown - porcelain fused to high noble metal.	$289.00
D2751	Crown - porcelain fused to predominantly base metal.	$248.00
D2752	Crown - porcelain fused to noble metal.	$266.00
D2780	Crown - 3/4 cast high noble metal.	$275.00
D2781	Crown - 3/4 cast predominantly base metal.	$239.00
D2782	Crown - 3/4 cast noble metal.	$250.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$298.00
D2790	Crown - full cast high noble metal.	$275.00
D2791	Crown - full cast predominantly base metal.	$239.00
D2792	Crown - full cast noble metal.	$250.00
D2794	Crown - titanium.	$275.00

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

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

CORE BUILD-UP

D2950	Core buildup, including any pins.	$60.00
D6973	Core build up for retainer, including any pins.	$60.00

CORE BUILDUP: D2950, D6973

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

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$95.00
D2954	Prefabricated post and core in addition to crown.	$79.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$48.00
D6980	Fixed partial denture repair, by report.	$54.00
D9120	Fixed partial denture sectioning.	$54.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$38.00
D3221	Pulpal debridement, primary and permanent teeth.	$38.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$57.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$44.00
D3333	Internal root repair of perforation defects.	$62.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$62.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$42.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$123.00
D3430	Retrograde filling - per root.	$49.00
D3450	Root amputation - per root.	$115.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$98.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$173.00
D3320	Endodontic therapy, bicuspid tooth.	$204.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$267.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$102.00
D3346	Retreatment of previous root canal therapy - anterior.	$215.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$248.00
D3348	Retreatment of previous root canal therapy - molar.	$308.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$178.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$205.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$222.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$79.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$113.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$57.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$155.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$78.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$284.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$142.00
D4263	Bone replacement graft - first site in quadrant.	$93.00
D4264	Bone replacement graft - each additional site in quadrant.	$70.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$46.00
D4270	Pedicle soft tissue graft procedure.	$209.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$221.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$258.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$124.00
D4275	Soft tissue allograft.	$221.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$258.00

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

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

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$171.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$58.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$29.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$43.00

CHEMOTHERAPEUTIC AGENTS: D4381

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

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$308.00
D5120	Complete denture - mandibular.	$299.00
D5130	Immediate denture - maxillary.	$334.00
D5140	Immediate denture - mandibular.	$323.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$222.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$257.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$222.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$257.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$191.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$222.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$257.00
D5810	Interim complete denture (maxillary).	$136.00
D5811	Interim complete denture (mandibular).	$143.00
D5820	Interim partial denture (maxillary).	$120.00
D5821	Interim partial denture (mandibular).	$126.00
D5860	Overdenture - complete, by report.	$308.00
D5861	Overdenture - partial, by report.	$357.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$308.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$357.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$308.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$357.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$17.00
D5411	Adjust complete denture - mandibular.	$16.00
D5421	Adjust partial denture - maxillary.	$18.00
D5422	Adjust partial denture - mandibular.	$17.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$40.00
D5660	Add clasp to existing partial denture.	$46.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$112.00
D5711	Rebase complete mandibular denture.	$119.00
D5720	Rebase maxillary partial denture.	$107.00
D5721	Rebase mandibular partial denture.	$113.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$31.00
D5851	Tissue conditioning, mandibular.	$34.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$257.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$280.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$280.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$257.00
D6062	Abutment supported cast metal crown (high noble metal).	$280.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$280.00
D6064	Abutment supported cast metal crown (noble metal).	$304.00
D6065	Implant supported porcelain/ceramic crown.	$257.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$257.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$280.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$280.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$257.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$280.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$280.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$304.00
D6075	Implant supported retainer for ceramic FPD.	$257.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$280.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$280.00
D6094	Abutment supported crown - (titanium).	$280.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$280.00
D6205	Pontic - indirect resin based composite.	$231.00
D6210	Pontic - cast high noble metal.	$280.00
D6211	Pontic - cast predominantly base metal.	$280.00
D6212	Pontic - cast noble metal.	$304.00
D6214	Pontic - titanium.	$280.00
D6240	Pontic - porcelain fused to high noble metal.	$280.00
D6241	Pontic - porcelain fused to predominantly base metal.	$280.00
D6242	Pontic - porcelain fused to noble metal.	$257.00
D6245	Pontic - porcelain/ceramic.	$257.00
D6250	Pontic - resin with high noble metal.	$280.00
D6251	Pontic - resin with predominantly base metal.	$257.00
D6252	Pontic - resin with noble metal.	$304.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$93.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$93.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$229.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$251.00
D6602	Inlay - cast high noble metal, two surfaces.	$206.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$226.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$178.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$195.00
D6606	Inlay - cast noble metal, two surfaces.	$187.00
D6607	Inlay - cast noble metal, three or more surfaces.	$206.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$247.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$272.00
D6610	Onlay - cast high noble metal, two surfaces.	$226.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$249.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$195.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$215.00
D6614	Onlay - cast noble metal, two surfaces.	$206.00
D6615	Onlay - cast noble metal, three or more surfaces.	$226.00
D6624	Inlay - titanium.	$226.00
D6634	Onlay - titanium.	$249.00
D6710	Crown - indirect resin based composite.	$231.00
D6720	Crown - resin with high noble metal.	$280.00
D6721	Crown - resin with predominantly base metal.	$145.00
D6722	Crown - resin with noble metal.	$234.00
D6740	Crown - porcelain/ceramic.	$257.00
D6750	Crown - porcelain fused to high noble metal.	$304.00
D6751	Crown - porcelain fused to predominantly base metal.	$280.00
D6752	Crown - porcelain fused to noble metal.	$257.00
D6780	Crown - 3/4 cast high noble metal.	$304.00
D6781	Crown - 3/4 cast predominantly base metal.	$280.00
D6782	Crown - 3/4 cast noble metal.	$257.00
D6783	Crown - 3/4 porcelain/ceramic.	$257.00
D6790	Crown - full cast high noble metal.	$280.00
D6791	Crown - full cast predominantly base metal.	$280.00
D6792	Crown - full cast noble metal.	$257.00
D6794	Crown - titanium.	$280.00
D6940	Stress breaker.	$78.00

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

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

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

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

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

TYPE 3 PROCEDURES

Maximum Covered Expense

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

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

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

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

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

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

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

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$84.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$84.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$45.00
D9973	External bleaching - per tooth.	$28.00
D9974	Internal bleaching - per tooth.	$34.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

ORTHODONTIC EXPENSE BENEFITS

Class Number 1

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

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

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

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

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. because of war or any act of war, declared or not.
10. To replace lost or stolen appliances.

Class Number 2

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

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

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

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

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. because of war or any act of war, declared or not.
10. To replace lost or stolen appliances.

Class Number 3

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

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

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

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

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. because of war or any act of war, declared or not.
10. To replace lost or stolen appliances.

Class Number 5

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

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

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

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

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
4. if the Insured's insurance under this section terminates.
5. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
6. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
8. because of war or any act of war, declared or not.
9. To replace lost or stolen appliances.

Class Number 6

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

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

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

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

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
4. if the Insured's insurance under this section terminates.
5. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
6. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
8. because of war or any act of war, declared or not.
9. To replace lost or stolen appliances.

Class Number 7

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

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

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

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

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
4. if the Insured's insurance under this section terminates.
5. for which the Insured is entitled to benefits under any workmen’s compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
6. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
8. because of war or any act of war, declared or not.
9. To replace lost or stolen appliances.

COORDINATION OF BENEFITS

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

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

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

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

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

    a. Any group or blanket insurance policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

        i. the parents are married;

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

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

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

    c. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the child's dental and/or eye care expenses of the Dependent child, the plan covering the Dependent child shall follow the order of benefit determination as stated in 2.b. above.

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

        i. the Plan of the Custodial Parent;

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

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

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

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

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

    f. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee,

member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

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

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

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

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

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

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

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

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

If expenses were incurred by a covered person due to the negligence of a third party, we have the right to recover the payments we made for those expenses from any and all damages collected from a third party for those same expenses, whether by action at law, settlement, or compromise. We have the right to recover these payments, to the extent of the payments we made, by the covered person, covered person's parents, if the covered person is a minor, or covered persons' legal representative.

We shall have the right to reimbursement out of all funds the covered person, the covered person's parents, if the covered person is a minor, or the covered person's legal representative, is or was able to obtain for the same expenses we have paid.

You are required to furnish us with any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

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

TIME OF PAYMENT. We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of nine percent per year on benefits for valid claims not paid within 30 days until the claim is settled. Interest amounting to less than one dollar will not be paid.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured unless otherwise agreed upon through your authorization or provider contracts.

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

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

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

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

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

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

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

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

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

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

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

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

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

i. necessary to calculate premiums;

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

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

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

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

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

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

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

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

The Participation Requirements are as follows:

Percentage of Members- N/A
Number of Members- 10

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

We may terminate this policy on the earlier of:

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

2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

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

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

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

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

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: NATIONAL ASSOCIATION OF REALTORS

whose main office address is: 430 N MICHIGAN AVE
CHICAGO, IL 60611-4011

for Group Policy No. 10-350635

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

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

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

NATIONAL ASSOCIATION OF REALTORS

(Full or Corporate Name of Applicant)

Dated at_____By_____
(Signature and Title)

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

This copy is to Remain Attached to the Policy

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL INSURANCE POLICY

The Policyholder	**NATIONAL ASSOCIATION OF REALTORS**		
		Policy Number	**10-350635**
State of Delivery	**Illinois**	**Plan Effective Date**	**July 1, 2010**
Premium Due Date 1st of each month.		**Renewal Date**	**July 1, 2012**

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

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

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

AMERITAS LIFE INSURANCE CORP.

Secretary

President

Notice of Grievance Procedures

In accordance with the Dental Care Patient Protection Act of the Illinois Insurance Code

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328 (Toll-Free)
402-309-2579 (FAX)

Please read this notice carefully. This notice contains important information about how to file grievances with your insurer. If you have questions, please feel free to contact the toll-free number shown above. Also, you always have the right to contact the Illinois Department of Insurance if you have a question or concern regarding your coverage under this contract. The Illinois Department may be contacted:

In Writing:	Illinois Department of Financial & Professional Regulation Division of Insurance Office of Consumer Health Insurance 320 West Washington Street Springfield, IL 62767-0001
By toll-free phone:	877-527-9431

I. Definitions

"Adverse Determination" means a determination by a health carrier that a health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced or terminated.

"Covered Person" means the policyholder, enrollee, claimant or their representatives, provider, agent or other entity which expresses a grievance or complaint involving the activities of the company or any persons involved in the solicitation, sale, service, execution of any transaction, or disposition of any funds of the policyholder.

"Grievance" means a written complaint on behalf of an insured person submitted by an insured person or a person, including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding:

(a) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination;

(b) claims payment, handling, or reimbursement for health care services;

(c) matters pertaining to the contractual relationship between a covered person and the insurer.

II. Review Process

You may ask your insurer to review its decisions involving your requests for benefit estimates or your requests to have your claims paid.

A written grievance concerning any matter, including an adverse determination may be submitted by a covered person. A written decision to the covered person will be provided within 15 working days after receiving a grievance and all information necessary for the insurer's review of the grievance. The person

or persons reviewing the grievance will not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. If a decision cannot be made within 15 working days due to circumstances beyond the insurer's control, the insurer may take up to an additional 15 working days to issue a written decision.

III. Written Decision

When a decision is issued after the review, the following information will be included in the written decision:

1. the names, titles and qualifying credentials of the persons participating in the grievance review process;
2. a statement of the reviewer's understanding of the grievance;
3. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision;
4. notice of the covered person's right to contact the Illinois Department of Insurance.

ILLINOIS
LIFE & HEALTH INSURANCE GUARANTY
ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

ILLINOIS LIFE AND
HEALTH INSURANCE GUARANTY ASSOCIATION

DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631-3404
(773) 714-8050

Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(217) 782-4515

Summary of General Purposes And
Current Limitations of Coverage

The Illinois law that provides for this safety net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") (215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions, and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

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1. Coverage:

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

a. life insurance, health insurance, and annuity contracts;
b. life, health or annuity certificates under direct group policies or contracts;
c. unallocated annuity contracts; and
d. contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

2. Exclusions from Coverage:

a. The Guaranty Association does not provide coverage for:

i. any policy or portion of a policy for which the individual has assumed the risk;
ii. any policy of reinsurance (unless an assumption certificate was issued);
iii. interest rate guarantees which exceed certain statutory limitations;
iv. certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
v. any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
vi. any stop loss insurance.

b. In addition, persons are not protected by the Guaranty Association if:

i. the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
ii. their policy was issued by an organization which is not a member insurer of the Association.

3. Limits on Amount of Coverage:

a. The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:

i. the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
ii. with respect to any one life, regardless of the number of policies, contracts, or certificates:

1) in the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or withdrawal values;
2) in the case of health insurance, $300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
3) with respect to annuities, $100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000 in benefits per contract holder, regardless of the number of contracts.

b. However, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

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

Benefit Class	Class Description
Class 1	Member Electing The Gold Plan
Class 2	Member Electing The Silver Plan
Class 3	Member Electing The Bronze Plan
Class 4	Member Electing The Value Plan
Class 5	Member Electing The Gold Plan
Class 6	Member Electing The Silver Plan
Class 7	Member Electing The Bronze Plan

Class Number 1

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

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

Maximum Amount - Each Benefit Period	$1,400

You and/or your dependents must be insured under the dental plan for 6 months to be eligible for Type 3 Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 2

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

Coinsurance Percentage:

Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,000

You and/or your dependents must be insured under the dental plan for 6 months to be eligible for Type 3 Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 3

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule
Maximum Amount - Each Benefit Period	$1,000

You and/or your dependents must be insured under the dental plan for 6 months to be eligible for Type 3 Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 4

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

Type 1 Procedures	$0
Type 2 Procedures - Each Benefit Period	$50

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Maximum Amount - Each Benefit Period	$1,000

Class Number 5

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

Coinsurance Percentage:

Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,400

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 6

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

Coinsurance Percentage:

Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,000

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 7

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

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

Maximum Amount - Each Benefit Period	$1,000

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

LASER VISION CORRECTION EXPENSE BENEFITS

Coinsurance Percentage:	100%

Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.

Class Number 1

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 2

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 3

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 4

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 5

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 6

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 7

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 1

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 2

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 3

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 5

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 6

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

Class Number 7

Ameritas Life Insurance Corp.
Laser Vision Correction Benefit Rider

This Laser Vision Correction Benefit Rider is attached to and made a part of Group Policy Number 10-350635 issued to NATIONAL ASSOCIATION OF REALTORS and each Certificate of Insurance issued under such Policy. It is hereby agreed that the Policy and each Certificate issued thereunder has been amended to provide benefits for the Covered Procedures as described below.

BENEFITS

If an Insured undergoes or receives a Covered Procedure rendered by a Provider, we will pay benefits as stated below. The Insured has the freedom of choice to receive laser vision correction treatment from any Provider.

Benefit Amount Payable For Covered Procedures Per Insured Person (Lifetime Maximum Benefit per Eye):

For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period	3rd Benefit Period	4th + Benefit Period
$125 per eye	$125 per eye	$250 per eye	$250 per eye

Exclusions and Limitations

- No benefit will be payable for any HCPCS Level II codes not listed below in the definition of Covered Procedures.
- No benefit will be payable for any Insured under the age of 18.
- Each Insured Person is eligible for only one Covered Procedure benefit payment per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

Definitions

Covered Procedures means only the following HCPCS Level II codes:

S0800: Laser in Situ Keratomileusis (LASIK). This would encompass standard LASIK, Custom LASIK, LASIK, LASIK with Wavefront Technology, CustomVue LASIK, and LASIK with IntraLase technology.

S0810: Photorefractive Keratectomy (PRK)

Benefit Period. Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31. Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a Benefit Period means the period from his or her effective date through December 31 of that year.

Provider. For the purposes of this benefit rider, a Provider refers to any person who is properly licensed under the laws of the state in which treatment is provided within the scope of the license.

This provision is effective on April 1, 2010

Ameritas Life Insurance Corp.

JoAnn M. Martin
President

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Classes 01,05	
Dental Care Insurance	$42.74 per Insured Person
	$37.52 Spouse Only
	$57.83 Child(ren) Only
	$95.36 Spouse & Child(ren)
Classes 02,06	
Dental Care Insurance	$33.48 per Insured Person
	$29.28 Spouse Only
	$44.68 Child(ren) Only
	$73.96 Spouse & Child(ren)
Classes 03,07	
Dental Care Insurance	$26.24 per Insured Person
	$22.88 Spouse Only
	$34.56 Child(ren) Only
	$57.44 Spouse & Child(ren)
Class 4	
Dental Care Insurance	$15.84 per Insured Person
	$13.60 Spouse Only
	$27.36 Child(ren) Only
	$40.96 Spouse & Child(ren)
Classes 01,05	
Orthodontic Insurance	$0.00 per Insured Person
	$0.00 Spouse Only
	$5.44 Child(ren) Only

	$5.44 Spouse & Child(ren)
Classes 02,06	
Orthodontic Insurance	$0.00 per Insured Person
	$0.00 Spouse Only
	$5.40 Child(ren) Only
	$5.44 Spouse & Child(ren)
Classes 03,07	
Orthodontic Insurance	$0.00 per Insured Person
	$0.00 Spouse Only
	$5.40 Child(ren) Only
	$5.40 Spouse & Child(ren)
Classes 01,02,03,05,06,07	
Laser Vision Correction Insurance	$1.40 per Insured Person
	$1.40 Spouse Only
	$0.76 Child(ren) Only
	$2.16 Spouse & Child(ren)

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

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

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

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata

charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 30 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter if we determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0.

Should this occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 30 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such change in the above situation shall at all times be subject to applicable state laws and regulations.

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

DEFINITIONS

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

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

INSURED refers to a person:

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

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

c. for whom the insurance has become effective.

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

Class Number 1

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

   i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

   ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

   "Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

Class Number 2

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

   i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

   ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

   "Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

Class Number 3

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

Class Number 4

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

Class Number 5

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

   i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

   ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

   "Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

Class Number 6

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

Class Number 7

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 26 years of age, (less than 30 years of age for discharged military dependents), for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. a grandchild that is a dependent of, and under interim court-ordered custody of the Insured;

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

c. each unmarried child age 26 or older who:

i. because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment; and

ii. is dependent on his or her parents or other care providers for lifetime care and supervision.

"Dependent on other care providers" is defined as requiring a Community Integrated Living Arrangement, group, home, supervised apartment, or other residential services licensed or

certified by the Department of Mental Health and Development Disabilities, the Department of Public Health, or the Department of Public Aid.

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

All Classes

TOTAL DISABILITY describes the Insured's Dependent as:

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

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

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

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

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

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

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

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

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

Class Number 1

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the gold plan.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

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

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the gold plan and has eligible dependents.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

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

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

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

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

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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

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

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

Class Number 2

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the silver plan.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

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

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the silver plan and has eligible dependents.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

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

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

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

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

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

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

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

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

Class Number 3

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the bronze plan.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

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

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

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

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

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

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

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the bronze plan and has eligible dependents.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

<u>Class Number 4</u>

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the value plan.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the value plan and has eligible dependents.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

Class Number 5

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the gold plan.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the gold plan and has eligible dependents.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

Class Number 6

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the silver plan.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the silver plan and has eligible dependents.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

Class Number 7

A member of the Eligible Class for Insurance is any member of the National Association of Realtors electing the bronze plan.

New Hampshire Residents are excluded from the Eligible Class for Insurance.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

COVERAGE FOR NEWBORN AND ADOPTED CHILDREN. A newborn child will be covered

from the date of birth. An adopted child, foster child and other child in court-ordered custody will be covered from the date of placement in the Insured's residence.

Coverage for a newborn child shall consist of coverage for covered dental expenses, subject to applicable deductibles, coinsurance percentages, maximums and limitations, resulting from care or treatment of congenital defects, birth abnormalities, including cleft lip and cleft palate and premature birth.

The Insured must give us written notice within 31 days of the date of birth or placement of a dependent child to start coverage. We will charge the applicable additional premium from the date of birth or placement for an adopted child.

A Member must be an Insured to also insure his or her dependents.

A member of the Eligible Class for Dependent Insurance is any member of the National Association of Realtors electing the bronze plan and has eligible dependents.

New Hampshire Residents are excluded from the Eligible Class for Dependent Insurance.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, no eligibility period is required.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

<u>All Classes</u>

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

Class Number 1

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 2

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 3

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 4

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 5

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 6

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 7

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

All Classes

CONTINUATION OF COVERAGE

Death, Divorce or Separation
For Spouses and Dependents

1. The Insured's spouse may continue coverage for themselves and any dependent children if coverage would terminate as a result of:

a. the death of the Insured; or
b. the dissolution of a marriage with, or legal separation from, the Insured.
c. the retirement of the Insured. (In this instance, the spouse must be at least age 55 on the date of retirement in order to elect continuation under this provision.)

provided:

i. the spouse makes election for continuation of coverage in the required time frames; and
ii. any required premium is paid.

2. Benefits

This continuation applies to all benefits payable under the policy.

3. How to Apply

a. Within 30 days of the entry of judgment of divorce or legal separation, or the death or retirement of the Insured, the spouse must notify the policyholder, including a mailing address, if he or she wishes to elect continuation of coverage.
b. Within 15 days of receipt of notice, the policyholder must mail us, the insurer, notice of the dissolution of the marriage or the death or retirement of the Insured.

c. Within 30 days after the date of receipt of a notice from the policyholder, we shall provide notice in writing the following:

i. an election form;
ii. the premium due;
iii. when and how payments must be made;
iv. instructions on returning the election form.

d. The spouse must affirmatively elect continuation with payment of the first monthly premium within 30 days of the date the notice is mailed by the insurer. Failure to elect continuation of coverage during this period shall terminate any future right to continuation.

4. Failure to Notify

If the insurer fails to send the notice of continuation, all premiums shall be waived from the date the notice was required until notice is sent.

5. Premiums

a. For former spouses who have not attained the age of 55 at the time coverage begins, the monthly premium shall be equal to the amount charged a member if the former spouse were a current member plus the amount the policyholder would contribute toward the premium if the former spouse were a current member.

b. For former spouses who have attained the age of 55 at the time coverage begins, the monthly premium shall be based on the same calculation as defined in 5.a. above. However, beginning 2 years after coverage begins, the monthly premium shall be based on this same calculation, plus an additional amount, not to exceed 20% of this calculation for costs of administration.

6. Termination

For former spouses who have not attained age 55 at the time coverage begins, such insurance will stop on

the earliest of:

a. the last day of the period for which the premium is paid;
b. the date that coverage would terminate under the terms of the existing policy if the Insured and spouse were still married to each other;
c. the date the spouse becomes insured under another group health plan;
d. the date the spouse remarries;
e. the expiration of 2 years from the date coverage began;
f. the date the policy terminates.

For former spouses who have attained age 55 at the time coverage begins, such insurance will stop on the earliest of:

a. the last day of the period for which the premium is paid;
b. the date on which coverage would terminate, except due to the retirement of an employee, under the terms of the existing policy if the Insured and spouse were still married to each other;
c. the date the spouse becomes insured under another group health plan;
d. the date the spouse remarries;
e. the date the spouse is eligible for coverage under Medicare, Title XVIII of the Federal Social Security Act;
f. the date the policy terminates.

7. Replacement of Policy
A new insurance carrier replacing coverage under which a continued person is covered must take over and continue such person's coverage.

Death of the Insured
Attainment of Limiting Age
Dependent Children

1. The Insured's dependent child may continue coverage under this policy
   a. in the event of the death of the Insured and the child is not eligible for coverage as a dependent under the provisions stated above; or
   b. the dependent child has attained the limiting age under the policy.

2. This continuation applies to all benefits payable under the policy.

3. How to Apply
   a. Death of the Insured
      Within 30 days of the death of the Insured, the dependent child or a responsible adult acting on behalf of the child must notify the policyholder or the insurer if he or she wishes to elect continuation of coverage.

      Within 15 days of receipt of notice, the policyholder must mail us, the insurer, notice of the death of the Insured and the mailing address of the dependent child. The policyholder shall immediately send a copy of the notice to the dependent child or responsible adult at the dependent child's residence.

   b. Attainment of Limiting Age
      In the event of the dependent child attaining the limiting age under the policy, if continuation coverage is desired, the dependent child shall give the policyholder or the insurer written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.

Within 15 days of receipt of notice, the policyholder must mail us, the insurer, notice of the request to continue coverage under this provision including the mailing address of the dependent child. The policyholder shall immediately send a copy of the notice to the dependent child or responsible adult at the dependent child's residence

4. Responsibilities of the Insurer

Within 30 days after the date of receipt of a notice from the policyholder, we shall provide notice in writing by certified mail, return receipt requested, notification to the dependent child or responsible adult that the policy may be continued. In addition, the notice will include:

i. an election form;
ii. the premium due;
iii. when and how payments must be made;
iv. instructions on returning the election form within thirty (30) days after the date it is received.

5. Electing Coverage

The dependent child or the responsible adult acting on behalf of the dependent child to exercise the election to continue coverage within such 30 day period shall terminate the continuation of benefits and the right to continuation.

6. Failure to Notify

If the insurer fails to send the notice of continuation, all premiums shall be waived from the date the notice was required until notice is sent and benefits will continue under the terms and provisions of the policy except where the benefits in existence at the time the company's notice was to be sent are terminated as to all members.

7. Premiums

The monthly premium will be equal to:

a. an amount, if any, that would be charged a member if the dependent child were a current member of the policyholder, plus;
b. an amount, if any, that the policyholder would contribute toward the premium if the dependent child were a current member.

Failure to pay the initial monthly premium within 30 days after the date of receipt of notice as defined in subsection (4) of this provision terminates the continuation benefits and the right to continuation benefits.

8. Termination

Coverage under this provision will terminate upon the earliest of:

a. the last day of the period for which the premium is paid;
b. the date that coverage would terminate under the terms of the existing policy if the dependent child was still an eligible dependent of the member;
c. the date on which the dependent child first becomes, or after the date of election, an insured member under any other group policy; or
d. the expiration of 2 years from the date continuation coverage began.

9. Replacement of Policy

If the group policy is cancelled and another insurance company contracts to provide group coverage to the policyholder, and continuation coverage is in effect for the dependent child at the time of cancellation, and the member is or would have been included under the new group policy, then the new insurer must also offer continuation coverage to the dependent child under the same terms and conditions as contained in this provision.

DENTAL EXPENSE BENEFITS

Class Number 1

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for Type 3 Procedures in the first 6 months the person is covered under this contract.

2. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits

provision found on 9260).

9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not.

Class Number 2

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is

amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group’s termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for Type 3 Procedures in the first 6 months the person is covered under this contract.

2. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under

this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not.

Class Number 3

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for Type 3 Procedures in the first 6 months the person is covered under this contract.

2. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any

such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

3. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not.

Class Number 4

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

2. for any procedure begun after the insured person's insurance under this contract terminates.

3. to replace lost or stolen appliances.

4. for any treatment which is for cosmetic purposes.

5. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

6. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

7. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

8. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

9. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

10. because of war or any act of war, declared or not.

<u>Class Number 5</u>

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown,

appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

2. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

8. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

11. because of war or any act of war, declared or not.

<u>Class Number 6</u>

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

2. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

8. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

10. for services that are not required for necessary care and treatment or are not within the generally

accepted parameters of care.

11. because of war or any act of war, declared or not.

Class Number 7

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

DENTAL EMERGENCY. Services for a dental emergency shall be defined as those services which are needed immediately because of an injury or unforseen medical condition. An example of emergency service are those services required for the temporary relief of pain, infection or swelling.

BENEFITS FOR DENTAL EMERGENCIES. Covered Expenses will be paid at the Participating Provider rate even though the service was performed by a Non-Participating Provider, if the services are rendered in connection with a Dental Emergency and either the Covered Person could not reasonably travel to a Participating Provider or the circumstances reasonably preclude the Covered Person from receiving the necessary care and treatment from a Participating Provider. However, if the Non-Participating Provider rate is greater, the Non-Participating Provider rate will apply.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Any expense which was incurred prior to termination of the group policy which was completed, installed or delivered within 90 days after the group's termination date will be considered a Covered Expense. No expense incurred after the group coverage terminates will be a Covered Expense.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

2. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

8. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

11. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

Class Number 1

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 2

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 3

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 4

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 5

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 6

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.

- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 7

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.

- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

All Classes

- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.

- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).

- Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.

- B/R means By Report.

- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.

- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.

- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

Class Number 1

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$33.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$25.00
D0150	Comprehensive oral evaluation - new or established patient.	$50.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$50.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$16.00
D0272	Bitewings - two films.	$30.00
D0273	Bitewings - three films.	$36.00
D0274	Bitewings - four films.	$46.00
D0277	Vertical bitewings - 7 to 8 films.	$70.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$70.00
D1120	Prophylaxis - child.	$49.00
D1203	Topical application of fluoride - child.	$27.00
D1204	Topical application of fluoride - adult.	$27.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$27.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$38.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$246.00
D1515	Space maintainer - fixed - bilateral.	$402.00
D1520	Space maintainer - removable - unilateral.	$385.00
D1525	Space maintainer - removable - bilateral.	$469.00
D1550	Re-cementation of space maintainer.	$50.00
D1555	Removal of fixed space maintainer.	$70.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$370.00
D8220	Fixed appliance therapy.	$370.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$41.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$41.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$83.00
D0330	Panoramic film.	$67.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$15.00
D0230	Intraoral - periapical each additional film.	$12.00
D0240	Intraoral - occlusal film.	$21.00
D0250	Extraoral - first film.	$27.00
D0260	Extraoral - each additional film.	$21.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$49.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$97.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$97.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$70.00
D2150	Amalgam - two surfaces, primary or permanent.	$89.00
D2160	Amalgam - three surfaces, primary or permanent.	$107.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$128.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$85.00
D2331	Resin-based composite - two surfaces, anterior.	$107.00
D2332	Resin-based composite - three surfaces, anterior.	$134.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$148.00
D2391	Resin-based composite - one surface, posterior.	$93.00
D2392	Resin-based composite - two surfaces, posterior.	$118.00
D2393	Resin-based composite - three surfaces, posterior.	$148.00
D2394	Resin-based composite - four or more surfaces, posterior.	$163.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$70.00
D2420	Gold foil - two surfaces.	$89.00
D2430	Gold foil - three surfaces.	$107.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$181.00
D2930	Prefabricated stainless steel crown - primary tooth.	$152.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$161.00
D2932	Prefabricated resin crown.	$181.00
D2933	Prefabricated stainless steel crown with resin window.	$181.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$181.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$56.00
D2915	Recement cast or prefabricated post and core.	$28.00
D2920	Recement crown.	$55.00
D6092	Recement implant/abutment supported crown.	$55.00
D6093	Recement implant/abutment supported fixed partial denture.	$55.00
D6930	Recement fixed partial denture.	$76.00

SEDATIVE FILLING

D2940	Sedative filling.	$51.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$86.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$89.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$89.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$74.00
D5610	Repair resin denture base.	$88.00
D5620	Repair cast framework.	$104.00
D5630	Repair or replace broken clasp.	$109.00
D5640	Replace broken teeth - per tooth.	$78.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$163.00
D5731	Reline complete mandibular denture (chairside).	$162.00
D5740	Reline maxillary partial denture (chairside).	$146.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$147.00
D5750	Reline complete maxillary denture (laboratory).	$243.00
D5751	Reline complete mandibular denture (laboratory).	$238.00
D5760	Reline maxillary partial denture (laboratory).	$243.00
D5761	Reline mandibular partial denture (laboratory).	$244.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$78.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$78.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$151.00
D7220	Removal of impacted tooth - soft tissue.	$188.00
D7230	Removal of impacted tooth - partially bony.	$250.00
D7240	Removal of impacted tooth - completely bony.	$292.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$333.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$156.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$369.00
D7261	Primary closure of a sinus perforation.	$369.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$223.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$223.00
D7280	Surgical access of an unerupted tooth.	$345.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$249.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$104.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$130.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$65.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$165.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$83.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$238.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$592.00
D7410	Excision of benign lesion up to 1.25 cm.	$236.00
D7411	Excision of benign lesion greater than 1.25 cm.	$302.00
D7412	Excision of benign lesion, complicated.	$333.00
D7413	Excision of malignant lesion up to 1.25 cm.	$319.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$233.00
D7415	Excision of malignant lesion, complicated.	$257.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$319.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$233.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$71.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$210.00
D7472	Removal of torus palatinus.	$210.00
D7473	Removal of torus mandibularis.	$210.00
D7485	Surgical reduction of osseous tuberosity.	$342.00
D7490	Radical resection of maxilla or mandible.	$319.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$105.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$121.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$97.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$266.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$266.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$350.00
D7910	Suture of recent small wounds up to 5 cm.	$47.00
D7911	Complicated suture - up to 5 cm.	$53.00
D7912	Complicated suture - greater than 5 cm.	$76.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$253.00
D7963	Frenuloplasty.	$316.00
D7970	Excision of hyperplastic tissue - per arch.	$195.00
D7972	Surgical reduction of fibrous tuberosity.	$310.00
D7980	Sialolithotomy.	$292.00
D7983	Closure of salivary fistula.	$93.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$316.00
D7286	Biopsy of oral tissue - soft.	$170.00
D7287	Exfoliative cytological sample collection.	$85.00
D7288	Brush biopsy - transepithelial sample collection.	$85.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$58.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$224.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$74.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$148.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$36.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$60.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$41.00
D9440	Office visit - after regularly scheduled hours.	$72.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$44.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$56.00
D9952	Occlusal adjustment - complete.	$281.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$49.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$27.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$85.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$305.00
D2520	Inlay - metallic - two surfaces.	$363.00
D2530	Inlay - metallic - three or more surfaces.	$391.00
D2610	Inlay - porcelain/ceramic - one surface.	$336.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$366.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$401.00
D2650	Inlay - resin-based composite - one surface.	$349.00
D2651	Inlay - resin-based composite - two surfaces.	$345.00
D2652	Inlay - resin-based composite - three or more surfaces.	$357.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$396.00
D2543	Onlay - metallic - three surfaces.	$441.00
D2544	Onlay - metallic - four or more surfaces.	$459.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$396.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$443.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$456.00
D2662	Onlay - resin-based composite - two surfaces.	$371.00
D2663	Onlay - resin-based composite - three surfaces.	$382.00
D2664	Onlay - resin-based composite - four or more surfaces.	$406.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$173.00
D2712	Crown - 3/4 resin-based composite (indirect).	$428.00
D2720	Crown - resin with high noble metal.	$441.00
D2721	Crown - resin with predominantly base metal.	$336.00
D2722	Crown - resin with noble metal.	$413.00
D2740	Crown - porcelain/ceramic substrate.	$476.00
D2750	Crown - porcelain fused to high noble metal.	$463.00
D2751	Crown - porcelain fused to predominantly base metal.	$397.00
D2752	Crown - porcelain fused to noble metal.	$425.00
D2780	Crown - 3/4 cast high noble metal.	$440.00
D2781	Crown - 3/4 cast predominantly base metal.	$383.00
D2782	Crown - 3/4 cast noble metal.	$400.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$476.00
D2790	Crown - full cast high noble metal.	$440.00
D2791	Crown - full cast predominantly base metal.	$383.00
D2792	Crown - full cast noble metal.	$400.00
D2794	Crown - titanium.	$440.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$96.00
D6973	Core build up for retainer, including any pins.	$96.00

CORE BUILDUP: D2950, D6973

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnotic data indicates significant tooth structure loss.

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$153.00
D2954	Prefabricated post and core in addition to crown.	$127.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$77.00
D6980	Fixed partial denture repair, by report.	$86.00
D9120	Fixed partial denture sectioning.	$86.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$61.00
D3221	Pulpal debridement, primary and permanent teeth.	$61.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$91.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$81.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$70.00
D3333	Internal root repair of perforation defects.	$99.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$99.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$67.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$197.00
D3430	Retrograde filling - per root.	$78.00
D3450	Root amputation - per root.	$185.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$156.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$277.00
D3320	Endodontic therapy, bicuspid tooth.	$326.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$427.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$163.00
D3346	Retreatment of previous root canal therapy - anterior.	$345.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$397.00
D3348	Retreatment of previous root canal therapy - molar.	$493.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$285.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$328.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$355.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$127.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$180.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$90.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$247.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$124.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$454.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$227.00
D4263	Bone replacement graft - first site in quadrant.	$148.00
D4264	Bone replacement graft - each additional site in quadrant.	$111.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$74.00
D4270	Pedicle soft tissue graft procedure.	$334.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$354.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$413.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$199.00
D4275	Soft tissue allograft.	$354.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$413.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$273.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$93.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$46.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$68.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$493.00
D5120	Complete denture - mandibular.	$478.00
D5130	Immediate denture - maxillary.	$534.00
D5140	Immediate denture - mandibular.	$517.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$354.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$410.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$354.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$410.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$306.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$354.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$410.00
D5810	Interim complete denture (maxillary).	$218.00
D5811	Interim complete denture (mandibular).	$230.00
D5820	Interim partial denture (maxillary).	$191.00
D5821	Interim partial denture (mandibular).	$201.00
D5860	Overdenture - complete, by report.	$493.00
D5861	Overdenture - partial, by report.	$571.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$493.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$571.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$493.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$571.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$28.00
D5411	Adjust complete denture - mandibular.	$26.00
D5421	Adjust partial denture - maxillary.	$29.00
D5422	Adjust partial denture - mandibular.	$28.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$64.00
D5660	Add clasp to existing partial denture.	$74.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$179.00
D5711	Rebase complete mandibular denture.	$190.00
D5720	Rebase maxillary partial denture.	$171.00
D5721	Rebase mandibular partial denture.	$181.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$50.00
D5851	Tissue conditioning, mandibular.	$54.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$411.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$449.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$449.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$411.00
D6062	Abutment supported cast metal crown (high noble metal).	$449.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$449.00
D6064	Abutment supported cast metal crown (noble metal).	$486.00
D6065	Implant supported porcelain/ceramic crown.	$411.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$411.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$449.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$449.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$411.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$449.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$449.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$486.00
D6075	Implant supported retainer for ceramic FPD.	$411.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$449.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$449.00
D6094	Abutment supported crown - (titanium).	$449.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$449.00
D6205	Pontic - indirect resin based composite.	$370.00
D6210	Pontic - cast high noble metal.	$449.00
D6211	Pontic - cast predominantly base metal.	$449.00
D6212	Pontic - cast noble metal.	$486.00
D6214	Pontic - titanium.	$449.00
D6240	Pontic - porcelain fused to high noble metal.	$449.00
D6241	Pontic - porcelain fused to predominantly base metal.	$449.00
D6242	Pontic - porcelain fused to noble metal.	$411.00
D6245	Pontic - porcelain/ceramic.	$411.00
D6250	Pontic - resin with high noble metal.	$449.00
D6251	Pontic - resin with predominantly base metal.	$411.00
D6252	Pontic - resin with noble metal.	$486.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$150.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$150.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$366.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$402.00
D6602	Inlay - cast high noble metal, two surfaces.	$329.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$362.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$284.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$313.00
D6606	Inlay - cast noble metal, two surfaces.	$299.00
D6607	Inlay - cast noble metal, three or more surfaces.	$329.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$396.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$435.00
D6610	Onlay - cast high noble metal, two surfaces.	$362.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$398.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$313.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$344.00
D6614	Onlay - cast noble metal, two surfaces.	$329.00
D6615	Onlay - cast noble metal, three or more surfaces.	$362.00
D6624	Inlay - titanium.	$362.00
D6634	Onlay - titanium.	$398.00
D6710	Crown - indirect resin based composite.	$370.00
D6720	Crown - resin with high noble metal.	$449.00
D6721	Crown - resin with predominantly base metal.	$233.00
D6722	Crown - resin with noble metal.	$374.00
D6740	Crown - porcelain/ceramic.	$411.00
D6750	Crown - porcelain fused to high noble metal.	$486.00
D6751	Crown - porcelain fused to predominantly base metal.	$449.00
D6752	Crown - porcelain fused to noble metal.	$411.00
D6780	Crown - 3/4 cast high noble metal.	$486.00
D6781	Crown - 3/4 cast predominantly base metal.	$449.00
D6782	Crown - 3/4 cast noble metal.	$411.00
D6783	Crown - 3/4 porcelain/ceramic.	$411.00
D6790	Crown - full cast high noble metal.	$449.00
D6791	Crown - full cast predominantly base metal.	$449.00
D6792	Crown - full cast noble metal.	$411.00
D6794	Crown - titanium.	$449.00
D6940	Stress breaker.	$124.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$135.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$135.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$72.00
D9973	External bleaching - per tooth.	$45.00
D9974	Internal bleaching - per tooth.	$54.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 2

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION		Maximum Covered Expense
D0120	Periodic oral evaluation - established patient.	$28.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$22.00
D0150	Comprehensive oral evaluation - new or established patient.	$43.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$43.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$14.00
D0272	Bitewings - two films.	$26.00
D0273	Bitewings - three films.	$31.00
D0274	Bitewings - four films.	$40.00
D0277	Vertical bitewings - 7 to 8 films.	$60.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$60.00
D1120	Prophylaxis - child.	$42.00
D1203	Topical application of fluoride - child.	$23.00
D1204	Topical application of fluoride - adult.	$23.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$23.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$33.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$212.00
D1515	Space maintainer - fixed - bilateral.	$347.00
D1520	Space maintainer - removable - unilateral.	$332.00
D1525	Space maintainer - removable - bilateral.	$405.00
D1550	Re-cementation of space maintainer.	$43.00
D1555	Removal of fixed space maintainer.	$60.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$319.00
D8220	Fixed appliance therapy.	$319.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$35.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$35.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$71.00
D0330	Panoramic film.	$57.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$13.00
D0230	Intraoral - periapical each additional film.	$10.00
D0240	Intraoral - occlusal film.	$18.00
D0250	Extraoral - first film.	$23.00
D0260	Extraoral - each additional film.	$18.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$42.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$83.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$83.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$60.00
D2150	Amalgam - two surfaces, primary or permanent.	$76.00
D2160	Amalgam - three surfaces, primary or permanent.	$92.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$110.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$73.00
D2331	Resin-based composite - two surfaces, anterior.	$92.00
D2332	Resin-based composite - three surfaces, anterior.	$115.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$127.00
D2391	Resin-based composite - one surface, posterior.	$80.00
D2392	Resin-based composite - two surfaces, posterior.	$101.00
D2393	Resin-based composite - three surfaces, posterior.	$127.00
D2394	Resin-based composite - four or more surfaces, posterior.	$140.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$60.00
D2420	Gold foil - two surfaces.	$76.00
D2430	Gold foil - three surfaces.	$92.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$155.00
D2930	Prefabricated stainless steel crown - primary tooth.	$130.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$138.00
D2932	Prefabricated resin crown.	$155.00
D2933	Prefabricated stainless steel crown with resin window.	$155.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$155.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$48.00
D2915	Recement cast or prefabricated post and core.	$24.00
D2920	Recement crown.	$47.00
D6092	Recement implant/abutment supported crown.	$47.00
D6093	Recement implant/abutment supported fixed partial denture.	$47.00
D6930	Recement fixed partial denture.	$65.00

SEDATIVE FILLING

D2940	Sedative filling.	$44.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$74.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$76.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$76.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$63.00
D5610	Repair resin denture base.	$75.00
D5620	Repair cast framework.	$89.00
D5630	Repair or replace broken clasp.	$93.00
D5640	Replace broken teeth - per tooth.	$67.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$140.00
D5731	Reline complete mandibular denture (chairside).	$139.00
D5740	Reline maxillary partial denture (chairside).	$125.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$126.00
D5750	Reline complete maxillary denture (laboratory).	$208.00
D5751	Reline complete mandibular denture (laboratory).	$204.00
D5760	Reline maxillary partial denture (laboratory).	$208.00
D5761	Reline mandibular partial denture (laboratory).	$209.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$67.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$67.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$129.00
D7220	Removal of impacted tooth - soft tissue.	$161.00
D7230	Removal of impacted tooth - partially bony.	$214.00
D7240	Removal of impacted tooth - completely bony.	$250.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$285.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$134.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$316.00
D7261	Primary closure of a sinus perforation.	$316.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$191.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$191.00
D7280	Surgical access of an unerupted tooth.	$296.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$213.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$89.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$111.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$56.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$141.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$71.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$204.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$507.00
D7410	Excision of benign lesion up to 1.25 cm.	$202.00
D7411	Excision of benign lesion greater than 1.25 cm.	$259.00
D7412	Excision of benign lesion, complicated.	$285.00
D7413	Excision of malignant lesion up to 1.25 cm.	$273.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$200.00
D7415	Excision of malignant lesion, complicated.	$220.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$273.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$200.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$61.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$180.00
D7472	Removal of torus palatinus.	$180.00
D7473	Removal of torus mandibularis.	$180.00
D7485	Surgical reduction of osseous tuberosity.	$293.00
D7490	Radical resection of maxilla or mandible.	$273.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$90.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$104.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$83.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$228.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$228.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$300.00
D7910	Suture of recent small wounds up to 5 cm.	$40.00
D7911	Complicated suture - up to 5 cm.	$45.00
D7912	Complicated suture - greater than 5 cm.	$65.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$217.00
D7963	Frenuloplasty.	$271.00
D7970	Excision of hyperplastic tissue - per arch.	$167.00
D7972	Surgical reduction of fibrous tuberosity.	$266.00
D7980	Sialolithotomy.	$250.00
D7983	Closure of salivary fistula.	$80.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$271.00
D7286	Biopsy of oral tissue - soft.	$146.00
D7287	Exfoliative cytological sample collection.	$73.00
D7288	Brush biopsy - transepithelial sample collection.	$73.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$50.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$192.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$63.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$127.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$31.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$51.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$35.00
D9440	Office visit - after regularly scheduled hours.	$62.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$38.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$48.00
D9952	Occlusal adjustment - complete.	$241.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$42.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$23.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$73.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$248.00
D2520	Inlay - metallic - two surfaces.	$295.00
D2530	Inlay - metallic - three or more surfaces.	$318.00
D2610	Inlay - porcelain/ceramic - one surface.	$273.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$297.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$326.00
D2650	Inlay - resin-based composite - one surface.	$284.00
D2651	Inlay - resin-based composite - two surfaces.	$280.00
D2652	Inlay - resin-based composite - three or more surfaces.	$290.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$321.00
D2543	Onlay - metallic - three surfaces.	$358.00
D2544	Onlay - metallic - four or more surfaces.	$373.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$321.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$360.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$371.00
D2662	Onlay - resin-based composite - two surfaces.	$301.00
D2663	Onlay - resin-based composite - three surfaces.	$310.00
D2664	Onlay - resin-based composite - four or more surfaces.	$330.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$140.00
D2712	Crown - 3/4 resin-based composite (indirect).	$348.00
D2720	Crown - resin with high noble metal.	$358.00
D2721	Crown - resin with predominantly base metal.	$273.00
D2722	Crown - resin with noble metal.	$335.00
D2740	Crown - porcelain/ceramic substrate.	$387.00
D2750	Crown - porcelain fused to high noble metal.	$376.00
D2751	Crown - porcelain fused to predominantly base metal.	$323.00
D2752	Crown - porcelain fused to noble metal.	$346.00
D2780	Crown - 3/4 cast high noble metal.	$358.00
D2781	Crown - 3/4 cast predominantly base metal.	$311.00
D2782	Crown - 3/4 cast noble metal.	$325.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$387.00
D2790	Crown - full cast high noble metal.	$358.00
D2791	Crown - full cast predominantly base metal.	$311.00
D2792	Crown - full cast noble metal.	$325.00
D2794	Crown - titanium.	$358.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$78.00
D6973	Core build up for retainer, including any pins.	$78.00

CORE BUILDUP: D2950, D6973

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnotic data indicates significant tooth structure loss.

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$124.00
D2954	Prefabricated post and core in addition to crown.	$103.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$63.00
D6980	Fixed partial denture repair, by report.	$70.00
D9120	Fixed partial denture sectioning.	$70.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$49.00
D3221	Pulpal debridement, primary and permanent teeth.	$49.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$74.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$66.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$57.00
D3333	Internal root repair of perforation defects.	$81.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$81.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$55.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$160.00
D3430	Retrograde filling - per root.	$63.00
D3450	Root amputation - per root.	$150.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$127.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$225.00
D3320	Endodontic therapy, bicuspid tooth.	$265.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$347.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$132.00
D3346	Retreatment of previous root canal therapy - anterior.	$280.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$323.00
D3348	Retreatment of previous root canal therapy - molar.	$400.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$231.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$267.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$289.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$103.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$146.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$74.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$201.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$101.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$369.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$185.00
D4263	Bone replacement graft - first site in quadrant.	$120.00
D4264	Bone replacement graft - each additional site in quadrant.	$91.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$60.00
D4270	Pedicle soft tissue graft procedure.	$272.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$287.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$335.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$162.00
D4275	Soft tissue allograft.	$287.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$335.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$222.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$75.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$38.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$55.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$400.00
D5120	Complete denture - mandibular.	$388.00
D5130	Immediate denture - maxillary.	$434.00
D5140	Immediate denture - mandibular.	$420.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$288.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$334.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$288.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$334.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$248.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$288.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$334.00
D5810	Interim complete denture (maxillary).	$177.00
D5811	Interim complete denture (mandibular).	$187.00
D5820	Interim partial denture (maxillary).	$156.00
D5821	Interim partial denture (mandibular).	$163.00
D5860	Overdenture - complete, by report.	$400.00
D5861	Overdenture - partial, by report.	$464.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$400.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$464.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$400.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$464.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$22.00
D5411	Adjust complete denture - mandibular.	$21.00
D5421	Adjust partial denture - maxillary.	$24.00
D5422	Adjust partial denture - mandibular.	$22.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$52.00
D5660	Add clasp to existing partial denture.	$60.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$146.00
D5711	Rebase complete mandibular denture.	$154.00
D5720	Rebase maxillary partial denture.	$139.00
D5721	Rebase mandibular partial denture.	$147.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$41.00
D5851	Tissue conditioning, mandibular.	$44.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$334.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$365.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$365.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$334.00
D6062	Abutment supported cast metal crown (high noble metal).	$365.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$365.00
D6064	Abutment supported cast metal crown (noble metal).	$395.00
D6065	Implant supported porcelain/ceramic crown.	$334.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$334.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$365.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$365.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$334.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$365.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$365.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$395.00
D6075	Implant supported retainer for ceramic FPD.	$334.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$365.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$365.00
D6094	Abutment supported crown - (titanium).	$365.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$365.00
D6205	Pontic - indirect resin based composite.	$301.00
D6210	Pontic - cast high noble metal.	$365.00
D6211	Pontic - cast predominantly base metal.	$365.00
D6212	Pontic - cast noble metal.	$395.00
D6214	Pontic - titanium.	$365.00
D6240	Pontic - porcelain fused to high noble metal.	$365.00
D6241	Pontic - porcelain fused to predominantly base metal.	$365.00
D6242	Pontic - porcelain fused to noble metal.	$334.00
D6245	Pontic - porcelain/ceramic.	$334.00
D6250	Pontic - resin with high noble metal.	$365.00
D6251	Pontic - resin with predominantly base metal.	$334.00
D6252	Pontic - resin with noble metal.	$395.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$122.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$122.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$297.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$327.00
D6602	Inlay - cast high noble metal, two surfaces.	$267.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$294.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$231.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$254.00
D6606	Inlay - cast noble metal, two surfaces.	$243.00
D6607	Inlay - cast noble metal, three or more surfaces.	$267.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$321.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$354.00
D6610	Onlay - cast high noble metal, two surfaces.	$294.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$323.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$254.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$279.00
D6614	Onlay - cast noble metal, two surfaces.	$267.00
D6615	Onlay - cast noble metal, three or more surfaces.	$294.00
D6624	Inlay - titanium.	$294.00
D6634	Onlay - titanium.	$323.00
D6710	Crown - indirect resin based composite.	$301.00
D6720	Crown - resin with high noble metal.	$365.00
D6721	Crown - resin with predominantly base metal.	$189.00
D6722	Crown - resin with noble metal.	$304.00
D6740	Crown - porcelain/ceramic.	$334.00
D6750	Crown - porcelain fused to high noble metal.	$395.00
D6751	Crown - porcelain fused to predominantly base metal.	$365.00
D6752	Crown - porcelain fused to noble metal.	$334.00
D6780	Crown - 3/4 cast high noble metal.	$395.00
D6781	Crown - 3/4 cast predominantly base metal.	$365.00
D6782	Crown - 3/4 cast noble metal.	$334.00
D6783	Crown - 3/4 porcelain/ceramic.	$334.00
D6790	Crown - full cast high noble metal.	$365.00
D6791	Crown - full cast predominantly base metal.	$365.00
D6792	Crown - full cast noble metal.	$334.00
D6794	Crown - titanium.	$365.00
D6940	Stress breaker.	$101.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$109.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$109.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$58.00
D9973	External bleaching - per tooth.	$36.00
D9974	Internal bleaching - per tooth.	$44.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 3

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$23.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$18.00
D0150	Comprehensive oral evaluation - new or established patient.	$36.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$36.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$12.00
D0272	Bitewings - two films.	$21.00
D0273	Bitewings - three films.	$26.00
D0274	Bitewings - four films.	$33.00
D0277	Vertical bitewings - 7 to 8 films.	$50.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$50.00
D1120	Prophylaxis - child.	$35.00
D1203	Topical application of fluoride - child.	$19.00
D1204	Topical application of fluoride - adult.	$19.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$19.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$28.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$177.00
D1515	Space maintainer - fixed - bilateral.	$289.00
D1520	Space maintainer - removable - unilateral.	$277.00
D1525	Space maintainer - removable - bilateral.	$337.00
D1550	Re-cementation of space maintainer.	$36.00
D1555	Removal of fixed space maintainer.	$50.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$266.00
D8220	Fixed appliance therapy.	$266.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$29.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$29.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$59.00
D0330	Panoramic film.	$47.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$11.00
D0230	Intraoral - periapical each additional film.	$8.00
D0240	Intraoral - occlusal film.	$15.00
D0250	Extraoral - first film.	$19.00
D0260	Extraoral - each additional film.	$15.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$35.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$69.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$69.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$50.00
D2150	Amalgam - two surfaces, primary or permanent.	$63.00
D2160	Amalgam - three surfaces, primary or permanent.	$77.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$92.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$61.00
D2331	Resin-based composite - two surfaces, anterior.	$77.00
D2332	Resin-based composite - three surfaces, anterior.	$96.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$106.00
D2391	Resin-based composite - one surface, posterior.	$67.00
D2392	Resin-based composite - two surfaces, posterior.	$84.00
D2393	Resin-based composite - three surfaces, posterior.	$106.00
D2394	Resin-based composite - four or more surfaces, posterior.	$117.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$50.00
D2420	Gold foil - two surfaces.	$63.00
D2430	Gold foil - three surfaces.	$77.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$129.00
D2930	Prefabricated stainless steel crown - primary tooth.	$108.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$115.00
D2932	Prefabricated resin crown.	$129.00
D2933	Prefabricated stainless steel crown with resin window.	$129.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$129.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$40.00
D2915	Recement cast or prefabricated post and core.	$20.00
D2920	Recement crown.	$39.00
D6092	Recement implant/abutment supported crown.	$39.00
D6093	Recement implant/abutment supported fixed partial denture.	$39.00
D6930	Recement fixed partial denture.	$54.00

SEDATIVE FILLING

D2940	Sedative filling.	$37.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$62.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$63.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$63.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$52.00
D5610	Repair resin denture base.	$62.00
D5620	Repair cast framework.	$74.00
D5630	Repair or replace broken clasp.	$77.00
D5640	Replace broken teeth - per tooth.	$56.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$117.00
D5731	Reline complete mandibular denture (chairside).	$116.00
D5740	Reline maxillary partial denture (chairside).	$104.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$105.00
D5750	Reline complete maxillary denture (laboratory).	$173.00
D5751	Reline complete mandibular denture (laboratory).	$170.00
D5760	Reline maxillary partial denture (laboratory).	$173.00
D5761	Reline mandibular partial denture (laboratory).	$174.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$56.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$56.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$107.00
D7220	Removal of impacted tooth - soft tissue.	$134.00
D7230	Removal of impacted tooth - partially bony.	$178.00
D7240	Removal of impacted tooth - completely bony.	$208.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$237.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$112.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$263.00
D7261	Primary closure of a sinus perforation.	$263.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$159.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$159.00
D7280	Surgical access of an unerupted tooth.	$247.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$177.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$74.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$92.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$47.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$117.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$59.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$170.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$422.00
D7410	Excision of benign lesion up to 1.25 cm.	$168.00
D7411	Excision of benign lesion greater than 1.25 cm.	$216.00
D7412	Excision of benign lesion, complicated.	$237.00
D7413	Excision of malignant lesion up to 1.25 cm.	$227.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$167.00
D7415	Excision of malignant lesion, complicated.	$183.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$227.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$167.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$51.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$150.00
D7472	Removal of torus palatinus.	$150.00
D7473	Removal of torus mandibularis.	$150.00
D7485	Surgical reduction of osseous tuberosity.	$244.00
D7490	Radical resection of maxilla or mandible.	$227.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$75.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$87.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$69.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$190.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$190.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$250.00
D7910	Suture of recent small wounds up to 5 cm.	$33.00
D7911	Complicated suture - up to 5 cm.	$37.00
D7912	Complicated suture - greater than 5 cm.	$54.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$181.00
D7963	Frenuloplasty.	$226.00
D7970	Excision of hyperplastic tissue - per arch.	$139.00
D7972	Surgical reduction of fibrous tuberosity.	$222.00
D7980	Sialolithotomy.	$208.00
D7983	Closure of salivary fistula.	$67.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$226.00
D7286	Biopsy of oral tissue - soft.	$122.00
D7287	Exfoliative cytological sample collection.	$61.00
D7288	Brush biopsy - transepithelial sample collection.	$61.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$42.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$160.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$52.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$106.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$26.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$42.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$29.00
D9440	Office visit - after regularly scheduled hours.	$52.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$32.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$40.00
D9952	Occlusal adjustment - complete.	$201.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$35.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$19.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$61.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$191.00
D2520	Inlay - metallic - two surfaces.	$227.00
D2530	Inlay - metallic - three or more surfaces.	$244.00
D2610	Inlay - porcelain/ceramic - one surface.	$210.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$229.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$250.00
D2650	Inlay - resin-based composite - one surface.	$218.00
D2651	Inlay - resin-based composite - two surfaces.	$215.00
D2652	Inlay - resin-based composite - three or more surfaces.	$223.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$247.00
D2543	Onlay - metallic - three surfaces.	$276.00
D2544	Onlay - metallic - four or more surfaces.	$287.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$247.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$277.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$285.00
D2662	Onlay - resin-based composite - two surfaces.	$232.00
D2663	Onlay - resin-based composite - three surfaces.	$239.00
D2664	Onlay - resin-based composite - four or more surfaces.	$254.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$108.00
D2712	Crown - 3/4 resin-based composite (indirect).	$268.00
D2720	Crown - resin with high noble metal.	$276.00
D2721	Crown - resin with predominantly base metal.	$210.00
D2722	Crown - resin with noble metal.	$258.00
D2740	Crown - porcelain/ceramic substrate.	$298.00
D2750	Crown - porcelain fused to high noble metal.	$289.00
D2751	Crown - porcelain fused to predominantly base metal.	$248.00
D2752	Crown - porcelain fused to noble metal.	$266.00
D2780	Crown - 3/4 cast high noble metal.	$275.00
D2781	Crown - 3/4 cast predominantly base metal.	$239.00
D2782	Crown - 3/4 cast noble metal.	$250.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$298.00
D2790	Crown - full cast high noble metal.	$275.00
D2791	Crown - full cast predominantly base metal.	$239.00
D2792	Crown - full cast noble metal.	$250.00
D2794	Crown - titanium.	$275.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$60.00
D6973	Core build up for retainer, including any pins.	$60.00

CORE BUILDUP: D2950, D6973

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnotic data indicates significant tooth structure loss.

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$95.00
D2954	Prefabricated post and core in addition to crown.	$79.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$48.00
D6980	Fixed partial denture repair, by report.	$54.00
D9120	Fixed partial denture sectioning.	$54.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$38.00
D3221	Pulpal debridement, primary and permanent teeth.	$38.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$57.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$44.00
D3333	Internal root repair of perforation defects.	$62.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$62.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$42.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$123.00
D3430	Retrograde filling - per root.	$49.00
D3450	Root amputation - per root.	$115.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$98.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$173.00
D3320	Endodontic therapy, bicuspid tooth.	$204.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$267.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$102.00
D3346	Retreatment of previous root canal therapy - anterior.	$215.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$248.00
D3348	Retreatment of previous root canal therapy - molar.	$308.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$178.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$205.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$222.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$79.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$113.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$57.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$155.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$78.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$284.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$142.00
D4263	Bone replacement graft - first site in quadrant.	$93.00
D4264	Bone replacement graft - each additional site in quadrant.	$70.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$46.00
D4270	Pedicle soft tissue graft procedure.	$209.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$221.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$258.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$124.00
D4275	Soft tissue allograft.	$221.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$258.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$171.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$58.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$29.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$43.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$308.00
D5120	Complete denture - mandibular.	$299.00
D5130	Immediate denture - maxillary.	$334.00
D5140	Immediate denture - mandibular.	$323.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$222.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$257.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$222.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$257.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$191.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$222.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$257.00
D5810	Interim complete denture (maxillary).	$136.00
D5811	Interim complete denture (mandibular).	$143.00
D5820	Interim partial denture (maxillary).	$120.00
D5821	Interim partial denture (mandibular).	$126.00
D5860	Overdenture - complete, by report.	$308.00
D5861	Overdenture - partial, by report.	$357.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$308.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$357.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$308.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$357.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$17.00
D5411	Adjust complete denture - mandibular.	$16.00
D5421	Adjust partial denture - maxillary.	$18.00
D5422	Adjust partial denture - mandibular.	$17.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$40.00
D5660	Add clasp to existing partial denture.	$46.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$112.00
D5711	Rebase complete mandibular denture.	$119.00
D5720	Rebase maxillary partial denture.	$107.00
D5721	Rebase mandibular partial denture.	$113.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$31.00
D5851	Tissue conditioning, mandibular.	$34.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$257.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$280.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$280.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$257.00
D6062	Abutment supported cast metal crown (high noble metal).	$280.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$280.00
D6064	Abutment supported cast metal crown (noble metal).	$304.00
D6065	Implant supported porcelain/ceramic crown.	$257.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$257.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$280.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$280.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$257.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$280.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$280.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$304.00
D6075	Implant supported retainer for ceramic FPD.	$257.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$280.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$280.00
D6094	Abutment supported crown - (titanium).	$280.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$280.00
D6205	Pontic - indirect resin based composite.	$231.00
D6210	Pontic - cast high noble metal.	$280.00
D6211	Pontic - cast predominantly base metal.	$280.00
D6212	Pontic - cast noble metal.	$304.00
D6214	Pontic - titanium.	$280.00
D6240	Pontic - porcelain fused to high noble metal.	$280.00
D6241	Pontic - porcelain fused to predominantly base metal.	$280.00
D6242	Pontic - porcelain fused to noble metal.	$257.00
D6245	Pontic - porcelain/ceramic.	$257.00
D6250	Pontic - resin with high noble metal.	$280.00
D6251	Pontic - resin with predominantly base metal.	$257.00
D6252	Pontic - resin with noble metal.	$304.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$93.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$93.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$229.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$251.00
D6602	Inlay - cast high noble metal, two surfaces.	$206.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$226.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$178.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$195.00
D6606	Inlay - cast noble metal, two surfaces.	$187.00
D6607	Inlay - cast noble metal, three or more surfaces.	$206.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$247.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$272.00
D6610	Onlay - cast high noble metal, two surfaces.	$226.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$249.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$195.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$215.00
D6614	Onlay - cast noble metal, two surfaces.	$206.00
D6615	Onlay - cast noble metal, three or more surfaces.	$226.00
D6624	Inlay - titanium.	$226.00
D6634	Onlay - titanium.	$249.00
D6710	Crown - indirect resin based composite.	$231.00
D6720	Crown - resin with high noble metal.	$280.00
D6721	Crown - resin with predominantly base metal.	$145.00
D6722	Crown - resin with noble metal.	$234.00
D6740	Crown - porcelain/ceramic.	$257.00
D6750	Crown - porcelain fused to high noble metal.	$304.00
D6751	Crown - porcelain fused to predominantly base metal.	$280.00
D6752	Crown - porcelain fused to noble metal.	$257.00
D6780	Crown - 3/4 cast high noble metal.	$304.00
D6781	Crown - 3/4 cast predominantly base metal.	$280.00
D6782	Crown - 3/4 cast noble metal.	$257.00
D6783	Crown - 3/4 porcelain/ceramic.	$257.00
D6790	Crown - full cast high noble metal.	$280.00
D6791	Crown - full cast predominantly base metal.	$280.00
D6792	Crown - full cast noble metal.	$257.00
D6794	Crown - titanium.	$280.00
D6940	Stress breaker.	$78.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$84.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$84.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$45.00
D9973	External bleaching - per tooth.	$28.00
D9974	Internal bleaching - per tooth.	$34.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 4

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$23.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$18.00
D0150	Comprehensive oral evaluation - new or established patient.	$36.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$36.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s).
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$76.00
D0330	Panoramic film.	$61.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$14.00
D0230	Intraoral - periapical each additional film.	$11.00
D0240	Intraoral - occlusal film.	$19.00
D0250	Extraoral - first film.	$24.00
D0260	Extraoral - each additional film.	$19.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

BITEWING FILMS		
D0270	Bitewing - single film.	$12.00
D0272	Bitewings - two films.	$21.00
D0273	Bitewings - three films.	$26.00
D0274	Bitewings - four films.	$33.00
D0277	Vertical bitewings - 7 to 8 films.	$50.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$50.00

TYPE 1 PROCEDURES

		Maximum Covered Expense
D1120	Prophylaxis - child.	$35.00
D1203	Topical application of fluoride - child.	$19.00
D1204	Topical application of fluoride - adult.	$19.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$19.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Benefits are considered for persons age 13 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$29.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$29.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$35.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$69.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$69.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

SEALANT		
D1351	Sealant - per tooth.	$22.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 13 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$50.00
D2150	Amalgam - two surfaces, primary or permanent.	$63.00
D2160	Amalgam - three surfaces, primary or permanent.	$77.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$92.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$61.00
D2331	Resin-based composite - two surfaces, anterior.	$77.00
D2332	Resin-based composite - three surfaces, anterior.	$96.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$106.00
D2391	Resin-based composite - one surface, posterior.	$67.00
D2392	Resin-based composite - two surfaces, posterior.	$84.00
D2393	Resin-based composite - three surfaces, posterior.	$106.00
D2394	Resin-based composite - four or more surfaces, posterior.	$117.00
D2410	Gold foil - one surface.	$50.00
D2420	Gold foil - two surfaces.	$63.00
D2430	Gold foil - three surfaces.	$77.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 2 PROCEDURES

		Maximum Covered Expense

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$129.00
D2930	Prefabricated stainless steel crown - primary tooth.	$108.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$115.00
D2932	Prefabricated resin crown.	$129.00
D2933	Prefabricated stainless steel crown with resin window.	$129.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$129.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$40.00
D2915	Recement cast or prefabricated post and core.	$20.00
D2920	Recement crown.	$39.00
D6092	Recement implant/abutment supported crown.	$39.00
D6093	Recement implant/abutment supported fixed partial denture.	$39.00
D6930	Recement fixed partial denture.	$54.00

SEDATIVE FILLING

D2940	Sedative filling.	$37.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$67.00
D3221	Pulpal debridement, primary and permanent teeth.	$67.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$102.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$90.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$78.00
D3333	Internal root repair of perforation defects.	$111.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$111.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$75.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$219.00
D3430	Retrograde filling - per root.	$87.00
D3450	Root amputation - per root.	$206.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$174.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$308.00
D3320	Endodontic therapy, bicuspid tooth.	$363.00
D3330	Endodontic therapy, molar.	$476.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$182.00
D3346	Retreatment of previous root canal therapy - anterior.	$384.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$442.00
D3348	Retreatment of previous root canal therapy - molar.	$549.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.

TYPE 2 PROCEDURES

- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

		Maximum Covered Expense
FULL MOUTH DEBRIDEMENT		
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$62.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE		
D4910	Periodontal maintenance.	$63.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR		
D5510	Repair broken complete denture base.	$63.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$52.00
D5610	Repair resin denture base.	$62.00
D5620	Repair cast framework.	$74.00
D5630	Repair or replace broken clasp.	$77.00
D5640	Replace broken teeth - per tooth.	$56.00
DENTURE RELINES		
D5730	Reline complete maxillary denture (chairside).	$117.00
D5731	Reline complete mandibular denture (chairside).	$116.00
D5740	Reline maxillary partial denture (chairside).	$104.00
D5741	Reline mandibular partial denture (chairside).	$105.00
D5750	Reline complete maxillary denture (laboratory).	$173.00
D5751	Reline complete mandibular denture (laboratory).	$170.00
D5760	Reline maxillary partial denture (laboratory).	$173.00
D5761	Reline mandibular partial denture (laboratory).	$174.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS		
D7111	Extraction, coronal remnants - deciduous tooth.	$56.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$56.00
OTHER ORAL SURGERY		
D7260	Oroantral fistula closure.	$263.00
D7261	Primary closure of a sinus perforation.	$263.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$159.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$159.00
D7280	Surgical access of an unerupted tooth.	$247.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$177.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$74.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$92.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$47.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$117.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$59.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$170.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$422.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7410	Excision of benign lesion up to 1.25 cm.	$168.00
D7411	Excision of benign lesion greater than 1.25 cm.	$216.00
D7412	Excision of benign lesion, complicated.	$237.00
D7413	Excision of malignant lesion up to 1.25 cm.	$227.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$167.00
D7415	Excision of malignant lesion, complicated.	$183.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$227.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$167.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$51.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$150.00
D7472	Removal of torus palatinus.	$150.00
D7473	Removal of torus mandibularis.	$150.00
D7485	Surgical reduction of osseous tuberosity.	$244.00
D7490	Radical resection of maxilla or mandible.	$227.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$75.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$87.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$69.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$190.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$190.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$250.00
D7910	Suture of recent small wounds up to 5 cm.	$33.00
D7911	Complicated suture - up to 5 cm.	$37.00
D7912	Complicated suture - greater than 5 cm.	$54.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$181.00
D7963	Frenuloplasty.	$226.00
D7970	Excision of hyperplastic tissue - per arch.	$139.00
D7972	Surgical reduction of fibrous tuberosity.	$222.00
D7980	Sialolithotomy.	$208.00
D7983	Closure of salivary fistula.	$67.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$226.00
D7286	Biopsy of oral tissue - soft.	$122.00
D7287	Exfoliative cytological sample collection.	$61.00
D7288	Brush biopsy - transepithelial sample collection.	$61.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$42.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$42.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$29.00
D9440	Office visit - after regularly scheduled hours.	$52.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$32.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

TYPE 2 PROCEDURES

		Maximum Covered Expense
OCCLUSAL ADJUSTMENT		
D9951	Occlusal adjustment - limited.	$40.00
D9952	Occlusal adjustment - complete.	$201.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS		
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$35.00
D2951	Pin retention - per tooth, in addition to restoration.	$19.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$61.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

Class Number 5

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$33.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$25.00
D0150	Comprehensive oral evaluation - new or established patient.	$50.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$50.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$16.00
D0272	Bitewings - two films.	$30.00
D0273	Bitewings - three films.	$36.00
D0274	Bitewings - four films.	$46.00
D0277	Vertical bitewings - 7 to 8 films.	$70.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$70.00
D1120	Prophylaxis - child.	$49.00
D1203	Topical application of fluoride - child.	$27.00
D1204	Topical application of fluoride - adult.	$27.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$27.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$38.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$246.00
D1515	Space maintainer - fixed - bilateral.	$402.00
D1520	Space maintainer - removable - unilateral.	$385.00
D1525	Space maintainer - removable - bilateral.	$469.00
D1550	Re-cementation of space maintainer.	$50.00
D1555	Removal of fixed space maintainer.	$70.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$370.00
D8220	Fixed appliance therapy.	$370.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$41.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$41.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$83.00
D0330	Panoramic film.	$67.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$15.00
D0230	Intraoral - periapical each additional film.	$12.00
D0240	Intraoral - occlusal film.	$21.00
D0250	Extraoral - first film.	$27.00
D0260	Extraoral - each additional film.	$21.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$49.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$97.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$97.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$70.00
D2150	Amalgam - two surfaces, primary or permanent.	$89.00
D2160	Amalgam - three surfaces, primary or permanent.	$107.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$128.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$85.00
D2331	Resin-based composite - two surfaces, anterior.	$107.00
D2332	Resin-based composite - three surfaces, anterior.	$134.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$148.00
D2391	Resin-based composite - one surface, posterior.	$93.00
D2392	Resin-based composite - two surfaces, posterior.	$118.00
D2393	Resin-based composite - three surfaces, posterior.	$148.00
D2394	Resin-based composite - four or more surfaces, posterior.	$163.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$70.00
D2420	Gold foil - two surfaces.	$89.00
D2430	Gold foil - three surfaces.	$107.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$181.00
D2930	Prefabricated stainless steel crown - primary tooth.	$152.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$161.00
D2932	Prefabricated resin crown.	$181.00
D2933	Prefabricated stainless steel crown with resin window.	$181.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$181.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$56.00
D2915	Recement cast or prefabricated post and core.	$28.00
D2920	Recement crown.	$55.00
D6092	Recement implant/abutment supported crown.	$55.00
D6093	Recement implant/abutment supported fixed partial denture.	$55.00
D6930	Recement fixed partial denture.	$76.00

SEDATIVE FILLING

D2940	Sedative filling.	$51.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$86.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$89.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$89.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$74.00
D5610	Repair resin denture base.	$88.00
D5620	Repair cast framework.	$104.00
D5630	Repair or replace broken clasp.	$109.00
D5640	Replace broken teeth - per tooth.	$78.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$163.00
D5731	Reline complete mandibular denture (chairside).	$162.00
D5740	Reline maxillary partial denture (chairside).	$146.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$147.00
D5750	Reline complete maxillary denture (laboratory).	$243.00
D5751	Reline complete mandibular denture (laboratory).	$238.00
D5760	Reline maxillary partial denture (laboratory).	$243.00
D5761	Reline mandibular partial denture (laboratory).	$244.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$78.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$78.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$151.00
D7220	Removal of impacted tooth - soft tissue.	$188.00
D7230	Removal of impacted tooth - partially bony.	$250.00
D7240	Removal of impacted tooth - completely bony.	$292.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$333.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$156.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$369.00
D7261	Primary closure of a sinus perforation.	$369.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$223.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$223.00
D7280	Surgical access of an unerupted tooth.	$345.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$249.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$104.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$130.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$65.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$165.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$83.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$238.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$592.00
D7410	Excision of benign lesion up to 1.25 cm.	$236.00
D7411	Excision of benign lesion greater than 1.25 cm.	$302.00
D7412	Excision of benign lesion, complicated.	$333.00
D7413	Excision of malignant lesion up to 1.25 cm.	$319.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$233.00
D7415	Excision of malignant lesion, complicated.	$257.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$319.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$233.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$236.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$302.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$71.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$210.00
D7472	Removal of torus palatinus.	$210.00
D7473	Removal of torus mandibularis.	$210.00
D7485	Surgical reduction of osseous tuberosity.	$342.00
D7490	Radical resection of maxilla or mandible.	$319.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$105.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$121.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$97.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$266.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$266.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$350.00
D7910	Suture of recent small wounds up to 5 cm.	$47.00
D7911	Complicated suture - up to 5 cm.	$53.00
D7912	Complicated suture - greater than 5 cm.	$76.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$253.00
D7963	Frenuloplasty.	$316.00
D7970	Excision of hyperplastic tissue - per arch.	$195.00
D7972	Surgical reduction of fibrous tuberosity.	$310.00
D7980	Sialolithotomy.	$292.00
D7983	Closure of salivary fistula.	$93.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$316.00
D7286	Biopsy of oral tissue - soft.	$170.00
D7287	Exfoliative cytological sample collection.	$85.00
D7288	Brush biopsy - transepithelial sample collection.	$85.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$58.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$224.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$74.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$148.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$36.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$60.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$41.00
D9440	Office visit - after regularly scheduled hours.	$72.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$44.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$56.00
D9952	Occlusal adjustment - complete.	$281.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$49.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$27.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$85.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$305.00
D2520	Inlay - metallic - two surfaces.	$363.00
D2530	Inlay - metallic - three or more surfaces.	$391.00
D2610	Inlay - porcelain/ceramic - one surface.	$336.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$366.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$401.00
D2650	Inlay - resin-based composite - one surface.	$349.00
D2651	Inlay - resin-based composite - two surfaces.	$345.00
D2652	Inlay - resin-based composite - three or more surfaces.	$357.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$396.00
D2543	Onlay - metallic - three surfaces.	$441.00
D2544	Onlay - metallic - four or more surfaces.	$459.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$396.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$443.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$456.00
D2662	Onlay - resin-based composite - two surfaces.	$371.00
D2663	Onlay - resin-based composite - three surfaces.	$382.00
D2664	Onlay - resin-based composite - four or more surfaces.	$406.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$173.00
D2712	Crown - 3/4 resin-based composite (indirect).	$428.00
D2720	Crown - resin with high noble metal.	$441.00
D2721	Crown - resin with predominantly base metal.	$336.00
D2722	Crown - resin with noble metal.	$413.00
D2740	Crown - porcelain/ceramic substrate.	$476.00
D2750	Crown - porcelain fused to high noble metal.	$463.00
D2751	Crown - porcelain fused to predominantly base metal.	$397.00
D2752	Crown - porcelain fused to noble metal.	$425.00
D2780	Crown - 3/4 cast high noble metal.	$440.00
D2781	Crown - 3/4 cast predominantly base metal.	$383.00
D2782	Crown - 3/4 cast noble metal.	$400.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$476.00
D2790	Crown - full cast high noble metal.	$440.00
D2791	Crown - full cast predominantly base metal.	$383.00
D2792	Crown - full cast noble metal.	$400.00
D2794	Crown - titanium.	$440.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$96.00
D6973	Core build up for retainer, including any pins.	$96.00

CORE BUILDUP: D2950, D6973

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnotic data indicates significant tooth structure loss.

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$153.00
D2954	Prefabricated post and core in addition to crown.	$127.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$77.00
D6980	Fixed partial denture repair, by report.	$86.00
D9120	Fixed partial denture sectioning.	$86.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$61.00
D3221	Pulpal debridement, primary and permanent teeth.	$61.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$91.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$81.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$70.00
D3333	Internal root repair of perforation defects.	$99.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$99.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$67.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$197.00
D3430	Retrograde filling - per root.	$78.00
D3450	Root amputation - per root.	$185.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$156.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$277.00
D3320	Endodontic therapy, bicuspid tooth.	$326.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$427.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$163.00
D3346	Retreatment of previous root canal therapy - anterior.	$345.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$397.00
D3348	Retreatment of previous root canal therapy - molar.	$493.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$285.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$328.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$355.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$127.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$180.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$90.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$247.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$124.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$454.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$227.00
D4263	Bone replacement graft - first site in quadrant.	$148.00
D4264	Bone replacement graft - each additional site in quadrant.	$111.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$74.00
D4270	Pedicle soft tissue graft procedure.	$334.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$354.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$413.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$199.00
D4275	Soft tissue allograft.	$354.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$413.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$273.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$93.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$46.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$68.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$493.00
D5120	Complete denture - mandibular.	$478.00
D5130	Immediate denture - maxillary.	$534.00
D5140	Immediate denture - mandibular.	$517.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$354.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$410.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$571.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$354.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$410.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$306.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$354.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$410.00
D5810	Interim complete denture (maxillary).	$218.00
D5811	Interim complete denture (mandibular).	$230.00
D5820	Interim partial denture (maxillary).	$191.00
D5821	Interim partial denture (mandibular).	$201.00
D5860	Overdenture - complete, by report.	$493.00
D5861	Overdenture - partial, by report.	$571.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$493.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$571.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$493.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$571.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$28.00
D5411	Adjust complete denture - mandibular.	$26.00
D5421	Adjust partial denture - maxillary.	$29.00
D5422	Adjust partial denture - mandibular.	$28.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$64.00
D5660	Add clasp to existing partial denture.	$74.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$179.00
D5711	Rebase complete mandibular denture.	$190.00
D5720	Rebase maxillary partial denture.	$171.00
D5721	Rebase mandibular partial denture.	$181.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$50.00
D5851	Tissue conditioning, mandibular.	$54.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$411.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$449.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$449.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$411.00
D6062	Abutment supported cast metal crown (high noble metal).	$449.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$449.00
D6064	Abutment supported cast metal crown (noble metal).	$486.00
D6065	Implant supported porcelain/ceramic crown.	$411.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$449.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$411.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$449.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$449.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$411.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$449.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$449.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$486.00
D6075	Implant supported retainer for ceramic FPD.	$411.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$449.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$449.00
D6094	Abutment supported crown - (titanium).	$449.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$449.00
D6205	Pontic - indirect resin based composite.	$370.00
D6210	Pontic - cast high noble metal.	$449.00
D6211	Pontic - cast predominantly base metal.	$449.00
D6212	Pontic - cast noble metal.	$486.00
D6214	Pontic - titanium.	$449.00
D6240	Pontic - porcelain fused to high noble metal.	$449.00
D6241	Pontic - porcelain fused to predominantly base metal.	$449.00
D6242	Pontic - porcelain fused to noble metal.	$411.00
D6245	Pontic - porcelain/ceramic.	$411.00
D6250	Pontic - resin with high noble metal.	$449.00
D6251	Pontic - resin with predominantly base metal.	$411.00
D6252	Pontic - resin with noble metal.	$486.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$150.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$150.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$366.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$402.00
D6602	Inlay - cast high noble metal, two surfaces.	$329.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$362.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$284.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$313.00
D6606	Inlay - cast noble metal, two surfaces.	$299.00
D6607	Inlay - cast noble metal, three or more surfaces.	$329.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$396.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$435.00
D6610	Onlay - cast high noble metal, two surfaces.	$362.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$398.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$313.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$344.00
D6614	Onlay - cast noble metal, two surfaces.	$329.00
D6615	Onlay - cast noble metal, three or more surfaces.	$362.00
D6624	Inlay - titanium.	$362.00
D6634	Onlay - titanium.	$398.00
D6710	Crown - indirect resin based composite.	$370.00
D6720	Crown - resin with high noble metal.	$449.00
D6721	Crown - resin with predominantly base metal.	$233.00
D6722	Crown - resin with noble metal.	$374.00
D6740	Crown - porcelain/ceramic.	$411.00
D6750	Crown - porcelain fused to high noble metal.	$486.00
D6751	Crown - porcelain fused to predominantly base metal.	$449.00
D6752	Crown - porcelain fused to noble metal.	$411.00
D6780	Crown - 3/4 cast high noble metal.	$486.00
D6781	Crown - 3/4 cast predominantly base metal.	$449.00
D6782	Crown - 3/4 cast noble metal.	$411.00
D6783	Crown - 3/4 porcelain/ceramic.	$411.00
D6790	Crown - full cast high noble metal.	$449.00
D6791	Crown - full cast predominantly base metal.	$449.00
D6792	Crown - full cast noble metal.	$411.00
D6794	Crown - titanium.	$449.00
D6940	Stress breaker.	$124.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$135.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$135.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$72.00
D9973	External bleaching - per tooth.	$45.00
D9974	Internal bleaching - per tooth.	$54.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 6

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation - established patient.	$28.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$22.00
D0150	Comprehensive oral evaluation - new or established patient.	$43.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$43.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$14.00
D0272	Bitewings - two films.	$26.00
D0273	Bitewings - three films.	$31.00
D0274	Bitewings - four films.	$40.00
D0277	Vertical bitewings - 7 to 8 films.	$60.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$60.00
D1120	Prophylaxis - child.	$42.00
D1203	Topical application of fluoride - child.	$23.00
D1204	Topical application of fluoride - adult.	$23.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$23.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$33.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$212.00
D1515	Space maintainer - fixed - bilateral.	$347.00
D1520	Space maintainer - removable - unilateral.	$332.00
D1525	Space maintainer - removable - bilateral.	$405.00
D1550	Re-cementation of space maintainer.	$43.00
D1555	Removal of fixed space maintainer.	$60.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$319.00
D8220	Fixed appliance therapy.	$319.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$35.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$35.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$71.00
D0330	Panoramic film.	$57.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$13.00
D0230	Intraoral - periapical each additional film.	$10.00
D0240	Intraoral - occlusal film.	$18.00
D0250	Extraoral - first film.	$23.00
D0260	Extraoral - each additional film.	$18.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$42.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$83.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$83.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$60.00
D2150	Amalgam - two surfaces, primary or permanent.	$76.00
D2160	Amalgam - three surfaces, primary or permanent.	$92.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$110.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$73.00
D2331	Resin-based composite - two surfaces, anterior.	$92.00
D2332	Resin-based composite - three surfaces, anterior.	$115.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$127.00
D2391	Resin-based composite - one surface, posterior.	$80.00
D2392	Resin-based composite - two surfaces, posterior.	$101.00
D2393	Resin-based composite - three surfaces, posterior.	$127.00
D2394	Resin-based composite - four or more surfaces, posterior.	$140.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$60.00
D2420	Gold foil - two surfaces.	$76.00
D2430	Gold foil - three surfaces.	$92.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$155.00
D2930	Prefabricated stainless steel crown - primary tooth.	$130.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$138.00
D2932	Prefabricated resin crown.	$155.00
D2933	Prefabricated stainless steel crown with resin window.	$155.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$155.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$48.00
D2915	Recement cast or prefabricated post and core.	$24.00
D2920	Recement crown.	$47.00
D6092	Recement implant/abutment supported crown.	$47.00
D6093	Recement implant/abutment supported fixed partial denture.	$47.00
D6930	Recement fixed partial denture.	$65.00

SEDATIVE FILLING

D2940	Sedative filling.	$44.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$74.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$76.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$76.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$63.00
D5610	Repair resin denture base.	$75.00
D5620	Repair cast framework.	$89.00
D5630	Repair or replace broken clasp.	$93.00
D5640	Replace broken teeth - per tooth.	$67.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$140.00
D5731	Reline complete mandibular denture (chairside).	$139.00
D5740	Reline maxillary partial denture (chairside).	$125.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$126.00
D5750	Reline complete maxillary denture (laboratory).	$208.00
D5751	Reline complete mandibular denture (laboratory).	$204.00
D5760	Reline maxillary partial denture (laboratory).	$208.00
D5761	Reline mandibular partial denture (laboratory).	$209.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$67.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$67.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$129.00
D7220	Removal of impacted tooth - soft tissue.	$161.00
D7230	Removal of impacted tooth - partially bony.	$214.00
D7240	Removal of impacted tooth - completely bony.	$250.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$285.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$134.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$316.00
D7261	Primary closure of a sinus perforation.	$316.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$191.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$191.00
D7280	Surgical access of an unerupted tooth.	$296.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$213.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$89.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$111.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$56.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$141.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$71.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$204.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$507.00
D7410	Excision of benign lesion up to 1.25 cm.	$202.00
D7411	Excision of benign lesion greater than 1.25 cm.	$259.00
D7412	Excision of benign lesion, complicated.	$285.00
D7413	Excision of malignant lesion up to 1.25 cm.	$273.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$200.00
D7415	Excision of malignant lesion, complicated.	$220.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$273.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$200.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$202.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$259.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$61.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$180.00
D7472	Removal of torus palatinus.	$180.00
D7473	Removal of torus mandibularis.	$180.00
D7485	Surgical reduction of osseous tuberosity.	$293.00
D7490	Radical resection of maxilla or mandible.	$273.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$90.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$104.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$83.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$228.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$228.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$300.00
D7910	Suture of recent small wounds up to 5 cm.	$40.00
D7911	Complicated suture - up to 5 cm.	$45.00
D7912	Complicated suture - greater than 5 cm.	$65.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$217.00
D7963	Frenuloplasty.	$271.00
D7970	Excision of hyperplastic tissue - per arch.	$167.00
D7972	Surgical reduction of fibrous tuberosity.	$266.00
D7980	Sialolithotomy.	$250.00
D7983	Closure of salivary fistula.	$80.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$271.00
D7286	Biopsy of oral tissue - soft.	$146.00
D7287	Exfoliative cytological sample collection.	$73.00
D7288	Brush biopsy - transepithelial sample collection.	$73.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$50.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$192.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$63.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$127.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$31.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$51.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$35.00
D9440	Office visit - after regularly scheduled hours.	$62.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$38.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$48.00
D9952	Occlusal adjustment - complete.	$241.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$42.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$23.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$73.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$248.00
D2520	Inlay - metallic - two surfaces.	$295.00
D2530	Inlay - metallic - three or more surfaces.	$318.00
D2610	Inlay - porcelain/ceramic - one surface.	$273.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$297.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$326.00
D2650	Inlay - resin-based composite - one surface.	$284.00
D2651	Inlay - resin-based composite - two surfaces.	$280.00
D2652	Inlay - resin-based composite - three or more surfaces.	$290.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$321.00
D2543	Onlay - metallic - three surfaces.	$358.00
D2544	Onlay - metallic - four or more surfaces.	$373.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$321.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$360.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$371.00
D2662	Onlay - resin-based composite - two surfaces.	$301.00
D2663	Onlay - resin-based composite - three surfaces.	$310.00
D2664	Onlay - resin-based composite - four or more surfaces.	$330.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$140.00
D2712	Crown - 3/4 resin-based composite (indirect).	$348.00
D2720	Crown - resin with high noble metal.	$358.00
D2721	Crown - resin with predominantly base metal.	$273.00
D2722	Crown - resin with noble metal.	$335.00
D2740	Crown - porcelain/ceramic substrate.	$387.00
D2750	Crown - porcelain fused to high noble metal.	$376.00
D2751	Crown - porcelain fused to predominantly base metal.	$323.00
D2752	Crown - porcelain fused to noble metal.	$346.00
D2780	Crown - 3/4 cast high noble metal.	$358.00
D2781	Crown - 3/4 cast predominantly base metal.	$311.00
D2782	Crown - 3/4 cast noble metal.	$325.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$387.00
D2790	Crown - full cast high noble metal.	$358.00
D2791	Crown - full cast predominantly base metal.	$311.00
D2792	Crown - full cast noble metal.	$325.00
D2794	Crown - titanium.	$358.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$78.00
D6973	Core build up for retainer, including any pins.	$78.00

CORE BUILDUP: D2950, D6973

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnotic data indicates significant tooth structure loss.

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$124.00
D2954	Prefabricated post and core in addition to crown.	$103.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$63.00
D6980	Fixed partial denture repair, by report.	$70.00
D9120	Fixed partial denture sectioning.	$70.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$49.00
D3221	Pulpal debridement, primary and permanent teeth.	$49.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$74.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$66.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$57.00
D3333	Internal root repair of perforation defects.	$81.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$81.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$55.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$160.00
D3430	Retrograde filling - per root.	$63.00
D3450	Root amputation - per root.	$150.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$127.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$225.00
D3320	Endodontic therapy, bicuspid tooth.	$265.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$347.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$132.00
D3346	Retreatment of previous root canal therapy - anterior.	$280.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$323.00
D3348	Retreatment of previous root canal therapy - molar.	$400.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$231.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$267.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$289.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$103.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$146.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$74.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$201.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$101.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$369.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$185.00
D4263	Bone replacement graft - first site in quadrant.	$120.00
D4264	Bone replacement graft - each additional site in quadrant.	$91.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$60.00
D4270	Pedicle soft tissue graft procedure.	$272.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$287.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$335.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$162.00
D4275	Soft tissue allograft.	$287.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$335.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$222.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$75.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$38.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$55.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$400.00
D5120	Complete denture - mandibular.	$388.00
D5130	Immediate denture - maxillary.	$434.00
D5140	Immediate denture - mandibular.	$420.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$288.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$334.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$464.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$288.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$334.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$248.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$288.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$334.00
D5810	Interim complete denture (maxillary).	$177.00
D5811	Interim complete denture (mandibular).	$187.00
D5820	Interim partial denture (maxillary).	$156.00
D5821	Interim partial denture (mandibular).	$163.00
D5860	Overdenture - complete, by report.	$400.00
D5861	Overdenture - partial, by report.	$464.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$400.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$464.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$400.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$464.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$22.00
D5411	Adjust complete denture - mandibular.	$21.00
D5421	Adjust partial denture - maxillary.	$24.00
D5422	Adjust partial denture - mandibular.	$22.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$52.00
D5660	Add clasp to existing partial denture.	$60.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$146.00
D5711	Rebase complete mandibular denture.	$154.00
D5720	Rebase maxillary partial denture.	$139.00
D5721	Rebase mandibular partial denture.	$147.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$41.00
D5851	Tissue conditioning, mandibular.	$44.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$334.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$365.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$365.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$334.00
D6062	Abutment supported cast metal crown (high noble metal).	$365.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$365.00
D6064	Abutment supported cast metal crown (noble metal).	$395.00
D6065	Implant supported porcelain/ceramic crown.	$334.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$365.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$334.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$365.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$365.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$334.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$365.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$365.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$395.00
D6075	Implant supported retainer for ceramic FPD.	$334.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$365.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$365.00
D6094	Abutment supported crown - (titanium).	$365.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$365.00
D6205	Pontic - indirect resin based composite.	$301.00
D6210	Pontic - cast high noble metal.	$365.00
D6211	Pontic - cast predominantly base metal.	$365.00
D6212	Pontic - cast noble metal.	$395.00
D6214	Pontic - titanium.	$365.00
D6240	Pontic - porcelain fused to high noble metal.	$365.00
D6241	Pontic - porcelain fused to predominantly base metal.	$365.00
D6242	Pontic - porcelain fused to noble metal.	$334.00
D6245	Pontic - porcelain/ceramic.	$334.00
D6250	Pontic - resin with high noble metal.	$365.00
D6251	Pontic - resin with predominantly base metal.	$334.00
D6252	Pontic - resin with noble metal.	$395.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$122.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$122.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$297.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$327.00
D6602	Inlay - cast high noble metal, two surfaces.	$267.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$294.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$231.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$254.00
D6606	Inlay - cast noble metal, two surfaces.	$243.00
D6607	Inlay - cast noble metal, three or more surfaces.	$267.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$321.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$354.00
D6610	Onlay - cast high noble metal, two surfaces.	$294.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$323.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$254.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$279.00
D6614	Onlay - cast noble metal, two surfaces.	$267.00
D6615	Onlay - cast noble metal, three or more surfaces.	$294.00
D6624	Inlay - titanium.	$294.00
D6634	Onlay - titanium.	$323.00
D6710	Crown - indirect resin based composite.	$301.00
D6720	Crown - resin with high noble metal.	$365.00
D6721	Crown - resin with predominantly base metal.	$189.00
D6722	Crown - resin with noble metal.	$304.00
D6740	Crown - porcelain/ceramic.	$334.00
D6750	Crown - porcelain fused to high noble metal.	$395.00
D6751	Crown - porcelain fused to predominantly base metal.	$365.00
D6752	Crown - porcelain fused to noble metal.	$334.00
D6780	Crown - 3/4 cast high noble metal.	$395.00
D6781	Crown - 3/4 cast predominantly base metal.	$365.00
D6782	Crown - 3/4 cast noble metal.	$334.00
D6783	Crown - 3/4 porcelain/ceramic.	$334.00
D6790	Crown - full cast high noble metal.	$365.00
D6791	Crown - full cast predominantly base metal.	$365.00
D6792	Crown - full cast noble metal.	$334.00
D6794	Crown - titanium.	$365.00
D6940	Stress breaker.	$101.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$109.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$109.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$58.00
D9973	External bleaching - per tooth.	$36.00
D9974	Internal bleaching - per tooth.	$44.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

Class Number 7

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION		Maximum Covered Expense
D0120	Periodic oral evaluation - established patient.	$23.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver.	$18.00
D0150	Comprehensive oral evaluation - new or established patient.	$36.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$36.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

BITEWING FILMS		
D0270	Bitewing - single film.	$12.00
D0272	Bitewings - two films.	$21.00
D0273	Bitewings - three films.	$26.00
D0274	Bitewings - four films.	$33.00
D0277	Vertical bitewings - 7 to 8 films.	$50.00

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$50.00
D1120	Prophylaxis - child.	$35.00
D1203	Topical application of fluoride - child.	$19.00
D1204	Topical application of fluoride - adult.	$19.00
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$19.00

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.

TYPE 1 PROCEDURES

		Maximum Covered Expense

- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351	Sealant - per tooth.	$28.00

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510	Space maintainer - fixed - unilateral.	$177.00
D1515	Space maintainer - fixed - bilateral.	$289.00
D1520	Space maintainer - removable - unilateral.	$277.00
D1525	Space maintainer - removable - bilateral.	$337.00
D1550	Re-cementation of space maintainer.	$36.00
D1555	Removal of fixed space maintainer.	$50.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210	Removable appliance therapy.	$266.00
D8220	Fixed appliance therapy.	$266.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$29.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$29.00

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$59.00
D0330	Panoramic film.	$47.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$11.00
D0230	Intraoral - periapical each additional film.	$8.00
D0240	Intraoral - occlusal film.	$15.00
D0250	Extraoral - first film.	$19.00
D0260	Extraoral - each additional film.	$15.00

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$35.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$69.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$69.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$50.00
D2150	Amalgam - two surfaces, primary or permanent.	$63.00
D2160	Amalgam - three surfaces, primary or permanent.	$77.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$92.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$61.00
D2331	Resin-based composite - two surfaces, anterior.	$77.00
D2332	Resin-based composite - three surfaces, anterior.	$96.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$106.00
D2391	Resin-based composite - one surface, posterior.	$67.00
D2392	Resin-based composite - two surfaces, posterior.	$84.00
D2393	Resin-based composite - three surfaces, posterior.	$106.00
D2394	Resin-based composite - four or more surfaces, posterior.	$117.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2410	Gold foil - one surface.	$50.00
D2420	Gold foil - two surfaces.	$63.00
D2430	Gold foil - three surfaces.	$77.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390	Resin-based composite crown, anterior.	$129.00
D2930	Prefabricated stainless steel crown - primary tooth.	$108.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$115.00
D2932	Prefabricated resin crown.	$129.00
D2933	Prefabricated stainless steel crown with resin window.	$129.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$129.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$40.00
D2915	Recement cast or prefabricated post and core.	$20.00
D2920	Recement crown.	$39.00
D6092	Recement implant/abutment supported crown.	$39.00
D6093	Recement implant/abutment supported fixed partial denture.	$39.00
D6930	Recement fixed partial denture.	$54.00

SEDATIVE FILLING

D2940	Sedative filling.	$37.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$62.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$63.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510	Repair broken complete denture base.	$63.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$52.00
D5610	Repair resin denture base.	$62.00
D5620	Repair cast framework.	$74.00
D5630	Repair or replace broken clasp.	$77.00
D5640	Replace broken teeth - per tooth.	$56.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside).	$117.00
D5731	Reline complete mandibular denture (chairside).	$116.00
D5740	Reline maxillary partial denture (chairside).	$104.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D5741	Reline mandibular partial denture (chairside).	$105.00
D5750	Reline complete maxillary denture (laboratory).	$173.00
D5751	Reline complete mandibular denture (laboratory).	$170.00
D5760	Reline maxillary partial denture (laboratory).	$173.00
D5761	Reline mandibular partial denture (laboratory).	$174.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth.	$56.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$56.00

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$107.00
D7220	Removal of impacted tooth - soft tissue.	$134.00
D7230	Removal of impacted tooth - partially bony.	$178.00
D7240	Removal of impacted tooth - completely bony.	$208.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$237.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$112.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	$263.00
D7261	Primary closure of a sinus perforation.	$263.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$159.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$159.00
D7280	Surgical access of an unerupted tooth.	$247.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$177.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$74.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$92.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$47.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.	$117.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$59.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$170.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$422.00
D7410	Excision of benign lesion up to 1.25 cm.	$168.00
D7411	Excision of benign lesion greater than 1.25 cm.	$216.00
D7412	Excision of benign lesion, complicated.	$237.00
D7413	Excision of malignant lesion up to 1.25 cm.	$227.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$167.00
D7415	Excision of malignant lesion, complicated.	$183.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$227.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$167.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$168.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$216.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$51.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$150.00
D7472	Removal of torus palatinus.	$150.00
D7473	Removal of torus mandibularis.	$150.00
D7485	Surgical reduction of osseous tuberosity.	$244.00
D7490	Radical resection of maxilla or mandible.	$227.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$75.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$87.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$69.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$190.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$190.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$250.00
D7910	Suture of recent small wounds up to 5 cm.	$33.00
D7911	Complicated suture - up to 5 cm.	$37.00
D7912	Complicated suture - greater than 5 cm.	$54.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$181.00
D7963	Frenuloplasty.	$226.00
D7970	Excision of hyperplastic tissue - per arch.	$139.00
D7972	Surgical reduction of fibrous tuberosity.	$222.00
D7980	Sialolithotomy.	$208.00
D7983	Closure of salivary fistula.	$67.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$226.00
D7286	Biopsy of oral tissue - soft.	$122.00
D7287	Exfoliative cytological sample collection.	$61.00
D7288	Brush biopsy - transepithelial sample collection.	$61.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$42.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

ANESTHESIA-GENERAL/IV

D9220	Deep sedation/general anesthesia - first 30 minutes.	$160.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$52.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$106.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$26.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	$42.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$29.00
D9440	Office visit - after regularly scheduled hours.	$52.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$32.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$40.00
D9952	Occlusal adjustment - complete.	$201.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	$35.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2951	Pin retention - per tooth, in addition to restoration.	$19.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$61.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS		Maximum Covered Expense
D2510	Inlay - metallic - one surface.	$191.00
D2520	Inlay - metallic - two surfaces.	$227.00
D2530	Inlay - metallic - three or more surfaces.	$244.00
D2610	Inlay - porcelain/ceramic - one surface.	$210.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$229.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$250.00
D2650	Inlay - resin-based composite - one surface.	$218.00
D2651	Inlay - resin-based composite - two surfaces.	$215.00
D2652	Inlay - resin-based composite - three or more surfaces.	$223.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$247.00
D2543	Onlay - metallic - three surfaces.	$276.00
D2544	Onlay - metallic - four or more surfaces.	$287.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$247.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$277.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$285.00
D2662	Onlay - resin-based composite - two surfaces.	$232.00
D2663	Onlay - resin-based composite - three surfaces.	$239.00
D2664	Onlay - resin-based composite - four or more surfaces.	$254.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$108.00
D2712	Crown - 3/4 resin-based composite (indirect).	$268.00
D2720	Crown - resin with high noble metal.	$276.00
D2721	Crown - resin with predominantly base metal.	$210.00
D2722	Crown - resin with noble metal.	$258.00
D2740	Crown - porcelain/ceramic substrate.	$298.00
D2750	Crown - porcelain fused to high noble metal.	$289.00
D2751	Crown - porcelain fused to predominantly base metal.	$248.00
D2752	Crown - porcelain fused to noble metal.	$266.00
D2780	Crown - 3/4 cast high noble metal.	$275.00
D2781	Crown - 3/4 cast predominantly base metal.	$239.00
D2782	Crown - 3/4 cast noble metal.	$250.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2783	Crown - 3/4 porcelain/ceramic.	$298.00
D2790	Crown - full cast high noble metal.	$275.00
D2791	Crown - full cast predominantly base metal.	$239.00
D2792	Crown - full cast noble metal.	$250.00
D2794	Crown - titanium.	$275.00

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$60.00
D6973	Core build up for retainer, including any pins.	$60.00

CORE BUILDUP: D2950, D6973

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnotic data indicates significant tooth structure loss.

POST AND CORE

D2952	Post and core in addition to crown, indirectly fabricated.	$95.00
D2954	Prefabricated post and core in addition to crown.	$79.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$48.00
D6980	Fixed partial denture repair, by report.	$54.00
D9120	Fixed partial denture sectioning.	$54.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$38.00
D3221	Pulpal debridement, primary and permanent teeth.	$38.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	$57.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$44.00
D3333	Internal root repair of perforation defects.	$62.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$62.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$42.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$123.00
D3430	Retrograde filling - per root.	$49.00
D3450	Root amputation - per root.	$115.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$98.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Endodontic therapy, anterior tooth.	$173.00
D3320	Endodontic therapy, bicuspid tooth.	$204.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3330	Endodontic therapy, molar.	$267.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$102.00
D3346	Retreatment of previous root canal therapy - anterior.	$215.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$248.00
D3348	Retreatment of previous root canal therapy - molar.	$308.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$178.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$205.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$222.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$79.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	$113.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	$57.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	$155.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	$78.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	$284.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	$142.00
D4263	Bone replacement graft - first site in quadrant.	$93.00
D4264	Bone replacement graft - each additional site in quadrant.	$70.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$46.00
D4270	Pedicle soft tissue graft procedure.	$209.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$221.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$258.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$124.00
D4275	Soft tissue allograft.	$221.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$258.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

TYPE 3 PROCEDURES

		Maximum Covered Expense
D4249	Clinical crown lengthening - hard tissue.	$171.00

NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$58.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$29.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$43.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110	Complete denture - maxillary.	$308.00
D5120	Complete denture - mandibular.	$299.00
D5130	Immediate denture - maxillary.	$334.00
D5140	Immediate denture - mandibular.	$323.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$222.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$257.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$357.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$222.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$257.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$191.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$222.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$257.00
D5810	Interim complete denture (maxillary).	$136.00
D5811	Interim complete denture (mandibular).	$143.00
D5820	Interim partial denture (maxillary).	$120.00
D5821	Interim partial denture (mandibular).	$126.00
D5860	Overdenture - complete, by report.	$308.00
D5861	Overdenture - partial, by report.	$357.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$308.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$357.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$308.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$357.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	$17.00
D5411	Adjust complete denture - mandibular.	$16.00
D5421	Adjust partial denture - maxillary.	$18.00
D5422	Adjust partial denture - mandibular.	$17.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5650	Add tooth to existing partial denture.	$40.00
D5660	Add clasp to existing partial denture.	$46.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$112.00
D5711	Rebase complete mandibular denture.	$119.00
D5720	Rebase maxillary partial denture.	$107.00
D5721	Rebase mandibular partial denture.	$113.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$31.00
D5851	Tissue conditioning, mandibular.	$34.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$257.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$280.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$280.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$257.00
D6062	Abutment supported cast metal crown (high noble metal).	$280.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$280.00
D6064	Abutment supported cast metal crown (noble metal).	$304.00
D6065	Implant supported porcelain/ceramic crown.	$257.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$280.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$257.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$280.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$280.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$257.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$280.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$280.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$304.00
D6075	Implant supported retainer for ceramic FPD.	$257.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$280.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$280.00
D6094	Abutment supported crown - (titanium).	$280.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$280.00
D6205	Pontic - indirect resin based composite.	$231.00
D6210	Pontic - cast high noble metal.	$280.00
D6211	Pontic - cast predominantly base metal.	$280.00
D6212	Pontic - cast noble metal.	$304.00
D6214	Pontic - titanium.	$280.00
D6240	Pontic - porcelain fused to high noble metal.	$280.00
D6241	Pontic - porcelain fused to predominantly base metal.	$280.00
D6242	Pontic - porcelain fused to noble metal.	$257.00
D6245	Pontic - porcelain/ceramic.	$257.00
D6250	Pontic - resin with high noble metal.	$280.00
D6251	Pontic - resin with predominantly base metal.	$257.00
D6252	Pontic - resin with noble metal.	$304.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$93.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$93.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$229.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$251.00
D6602	Inlay - cast high noble metal, two surfaces.	$206.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$226.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$178.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$195.00
D6606	Inlay - cast noble metal, two surfaces.	$187.00
D6607	Inlay - cast noble metal, three or more surfaces.	$206.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6608	Onlay - porcelain/ceramic, two surfaces.	$247.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$272.00
D6610	Onlay - cast high noble metal, two surfaces.	$226.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$249.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$195.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$215.00
D6614	Onlay - cast noble metal, two surfaces.	$206.00
D6615	Onlay - cast noble metal, three or more surfaces.	$226.00
D6624	Inlay - titanium.	$226.00
D6634	Onlay - titanium.	$249.00
D6710	Crown - indirect resin based composite.	$231.00
D6720	Crown - resin with high noble metal.	$280.00
D6721	Crown - resin with predominantly base metal.	$145.00
D6722	Crown - resin with noble metal.	$234.00
D6740	Crown - porcelain/ceramic.	$257.00
D6750	Crown - porcelain fused to high noble metal.	$304.00
D6751	Crown - porcelain fused to predominantly base metal.	$280.00
D6752	Crown - porcelain fused to noble metal.	$257.00
D6780	Crown - 3/4 cast high noble metal.	$304.00
D6781	Crown - 3/4 cast predominantly base metal.	$280.00
D6782	Crown - 3/4 cast noble metal.	$257.00
D6783	Crown - 3/4 porcelain/ceramic.	$257.00
D6790	Crown - full cast high noble metal.	$280.00
D6791	Crown - full cast predominantly base metal.	$280.00
D6792	Crown - full cast noble metal.	$257.00
D6794	Crown - titanium.	$280.00
D6940	Stress breaker.	$78.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated.	$84.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$84.00

BLEACHING (COSMETIC)

D9972	External bleaching - per arch.	$45.00
D9973	External bleaching - per tooth.	$28.00
D9974	Internal bleaching - per tooth.	$34.00

BLEACHING: D9972

- Each arch is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 14 and over.

ORTHODONTIC EXPENSE BENEFITS

Class Number 1

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. because of war or any act of war, declared or not.
10. To replace lost or stolen appliances.

Class Number 2

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. because of war or any act of war, declared or not.
10. To replace lost or stolen appliances.

Class Number 3

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. before the Insured has been insured under this section for at least 12 consecutive months.
4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
5. if the Insured's insurance under this section terminates.
6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
9. because of war or any act of war, declared or not.
10. To replace lost or stolen appliances.

Class Number 5

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
4. if the Insured's insurance under this section terminates.
5. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
6. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
8. because of war or any act of war, declared or not.
9. To replace lost or stolen appliances.

Class Number 6

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
4. if the Insured's insurance under this section terminates.
5. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
6. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
8. because of war or any act of war, declared or not.
9. To replace lost or stolen appliances.

Class Number 7

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun on or after the Insured's 17 birthday.
2. for a Program begun before the Insured became covered under this section.
3. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.
4. if the Insured's insurance under this section terminates.
5. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
6. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.
7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.
8. because of war or any act of war, declared or not.
9. To replace lost or stolen appliances.

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

        If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

    c. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the child's dental and/or eye care expenses of the Dependent child, the plan covering the Dependent child shall follow the order of benefit determination as stated in 2.b. above.

    d. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

        However, if the specific terms of a court decree establish a parent's responsibility for the child's Dental expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

    e. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee,

member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

g. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

If expenses were incurred by a covered person due to the negligence of a third party, we have the right to recover the payments we made for those expenses from any and all damages collected from a third party for those same expenses, whether by action at law, settlement, or compromise. We have the right to recover these payments, to the extent of the payments we made, by the covered person, covered person's parents, if the covered person is a minor, or covered persons' legal representative.

We shall have the right to reimbursement out of all funds the covered person, the covered person's parents, if the covered person is a minor, or the covered person's legal representative, is or was able to obtain for the same expenses we have paid.

You are required to furnish us with any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90-day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of nine percent per year on benefits for valid claims not paid within 30 days until the claim is settled. Interest amounting to less than one dollar will not be paid.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured unless otherwise agreed upon through your authorization or provider contracts.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

GENERAL PROVISIONS (CONTINUED)

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to avoid the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	N/A
Number of Members-	10

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: NATIONAL ASSOCIATION OF REALTORS

whose main office address is: 430 N MICHIGAN AVE
CHICAGO, IL 60611-4011

for Group Policy No. 10-350635

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

NATIONAL ASSOCIATION OF REALTORS

(Full or Corporate Name of Applicant)

Dated at_____By_____
(Signature and Title)

On_____, 20__ Witness_____
(To be signed by Resident Agent where required by law)

This copy is to Remain Attached to the Policy

AMERITAS
LIFE INSURANCE CORP.
A UNIFI Company

5900 O Street / P.O. Box 81889 / Lincoln, NE 68501-1889

September 24, 2010

Arkansas Insurance Department
Compliance - Life & Health
1200 West Third Street
Little Rock AR 72201-1904

RE: Request for Review - Eligibility of a Group under §23-86-106(2)(A)
National Association of Realtors

Dear Sir/Madam:

Enclosed for your review and approval is the above captioned out-of-state group. Ameritas Life Insurance Corp. ("Ameritas") is an Arkansas licensed insurer and has recently issued a group policy providing dental benefits to the members of the National Association of Realtors (NAR).

NAR requested some changes to be made to their original policy and certificates. We have made these changes we could within the variability of the filing. This association was originally approved by your department on January 15, 2010 under SERFF Tracking Number: AMFA-126386513. All the required documents were provided under this filing. The new plan effective date is July 1, 2010. We have provided both the red-line version and the final print version of the policy for your review. Per email from Ms. Rosalind Minor on September 14, 2010, we were advised we only need to provide these two documents. Ameritas has reviewed the By-Laws of the Association. A copy was provided at the original filing. In addition, Ameritas also reviewed the statutory provisions of Arkansas Code to ensure that this potential group constituted an eligible group under §23-86-106.

Specifically, under Arkansas §23-86-106(2)(A), an eligible group is defined as an association, including a labor union, which shall have a constitution or by-laws **and the Insurance Commissioner finds**, regardless of where the association is domiciled or does business, which has been organized and is maintained in good faith for purposes other than that of obtaining insurance or insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

The National Association of Realtors was founded as the National Association of Real Estate Exchanges on May 12, 1908 at the YMCA Auditorium in Chicago, IL. With 120 founding members, 19 Boards, and one State Association, the National Association of Real Estate Exchanges' objective was "to unite the real estate men of America for the purpose of effectively exerting a combined influence upon matters affecting real estate interests."

In 1916, the National Association of Real Estate Exchange's name was changed to The National Association of Real Estate Boards (NAREB). That same year, the term "REALTOR," identifying real estate professionals who are members of the National Association and subscribers to its strict Code of Ethics, was devised by Charles N. Chadbourn, a past president of the Minneapolis Real Estate Board.

In 1972, the name of the National Association of Real Estate Boards was changed to the National Association of REALTORS® (NAR).

The Association became the largest trade association in the United States in the early 1970s, with over 400,000 members. Today, the National Association of REALTORS® has over 1.2 million members, 54 State Associations (including Guam, Puerto Rico, and the Virgin Islands) and more than 1,400 local Associations. NAR was incorporated in Illinois.

NAR's mission is to help its members become more profitable and successful. The association was formed to:

- To provide a facility for education, research and exchange of information for those engaged in the recognized branches of the real estate business, including brokerage, management, mortgage financing, appraising, counseling, land development and building, and education and research in real estate, in the United States of America, its insular possessions and the Commonwealth of Puerto Rico, for the purpose of raising the standards of real estate practice and preserving the right of property ownership in the interest of the public welfare can directly benefit from corporate discounts on products and services that are used on a regular basis.
- To promote and maintain high standards of conduct in the transaction of the real estate business;
- To formulate and promulgate a Code of Ethics for the members of the National Association;
- To license its members the right to display the emblem seal of the National Association and the right to use the terms REALTOR®, REALTORS®, or REALTOR-ASSOCIATE® which terms are hereby defined as designating a person or persons engaged in the real estate business who is a Board Member or Individual Member of the NAR .
- To inform the public of the advantages of transacting business with REALTORS®, and to encourage the use by Members of the term REALTOR® and the emblem seal.

Ameritas has already filed the group policy with Illinois and a copy is attached for your reference. Following approval by your Department, Ameritas will issue a certificate form to any Arkansas members of this group under certificate form 9021 Rev. 03-08. The content of this certificate form was previously approved by the Department on August 4, 2009 for true employer groups. There will be seven different plan options.

The current address for this out-of-state group is:
National Association of Realtors
430 North Michigan Avenue
Chicago, Illinois 60611-4087

The National Association does not maintain an office in the state of Arkansas. There are member boards in the state of Arkansas. There is a state association and 37 local associations. Each member board is a separate corporation related to NAR by membership as described in the Constitution. The officers and committees of the state association and the local association are related to those organizations and have no status in NAR except as members.

NAR assesses dues to member boards which are calculated based upon the number of members and non-member licensees affiliated with members times $80. There is currently a special assessment in place to finance a national television and radio public awareness campaign of $35 per member. They do not receive any compensation by the insurer issuing the contracts to their members.

NAR carries on all of the usual and customary activities associated with a professional trade association. Some are described below and others are discussed in NAR's membership kit.

Outlined below are just a few of the many benefits you receive as a member:

- REALTOR.org/NARHelpsYou: Find dozens of helpful products and resources, including the just-released FHA Toolkit, for free online or for purchase at a steep discount at the REALTOR® store.
- REALTOR® Magazine: A $56 value, the magazine's valuable content, business tips and tools are provided to you free every month as a member.

- Legislative Affairs: NAR is in Washington, fighting every day to protect their profession, and RPAC contributions provide funds to gain influence with decision makers—all of which result in value to its members every day.
- Code of Ethics: What sets REALTORS® apart from the rest—and protects consumers as we navigate through the process together. Every member is required to complete 2 ½ hours of Ethics training every four years.
- Public Awareness Campaign: In its 11th year, the campaign is positively affecting the how consumers view REALTORS®, including educating them on the important distinction between working with a REALTORS® and someone who is not a member.
- Professional Development: Numerous certifications and designations are available to members to further his/her expertise.
- Online Resources: A member can post his/her listings for free on REALTOR.com, the #1 most visited homes-for-sale site. And REALTOR.org provides the member with a wealth of information and the latest industry news online, any time, always free to the member.
- REALTORS are individuals who are engaged in any one of several different aspect of the real estate business who have committed to conduct that business in a manner consistent with NAR's Code of Ethics and have agreed to abide by the Bylaws, rules and regulations of the national, state and local association of REALTORS. In addition, local association may precondition membership upon an applicant being properly licensed or certified by the appropriate real estate commission or appraisal board, the applicant not having been sanctioned for conduct involving unprofessional conduct, including violations of the Code of Ethics as determined by other member boards, completion of a orientation program and no recent or pending bankruptcy.

NAR does not directly recruit individuals for membership. This may be done by local associations in their communities. If lists are used the most likely source would be the state government's list of licensees.

There are 7624 REALTORS in Arkansas, but Ameritas does not give out that list. There are currently no members that obtain Ameritas' dental benefits. The effective date of these benefits will be 01/01/2010.

This form is in final print. When scored with the policy, this form achieves a 50 on the Flesch Readability Scale.

Thank you for your review of this filing. If you need anything additional, please feel free to contact me at 800-745-1112, ext. 82444, FAX 402-309-2573 or email jlandon@ameritas.com.

Sincerely,

Janis Landon
Senior Contract Analyst