

**GROUP  
DENTAL  
PLAN**

**UNITED TEACHERS OF ISLAND TREES WELFARE TRUST FUND**

**UNITED TEACHERS OF ISLAND TREES**

**Plan Number: 26-301528**

Administered by:



Ameritas Life Insurance Corp. of New York

## **Non-Insurance Products/Services**

From time to time we may arrange, at no additional cost to you or your group, for third-party service providers to provide you access to discounted goods and/or services, such as purchase of eye wear or prescription drugs. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your coverage or the termination of our arrangements with the providers, whichever comes first.

Dental procedures not covered under your plan may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law.

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**SCHEDULE OF BENEFITS  
OUTLINE OF COVERAGE**

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

<u>Benefit Class</u>	<u>Class Description</u>
Class 1	Eligible Employee Electing Dental

**DENTAL EXPENSE BENEFITS**

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

Deductible Amount:

When a Participating Provider is used:	
Type 1, Type 2, and Type 3 Procedures	\$0

When a Non-Participating Provider is used:	
Type 1, Type 2, and Type 3 Procedures	\$0

	Participating Provider	Non-Participating Provider
Benefit Percentage:		
Type 1 Procedures	100% of Schedule	100% of Schedule
Type 2 Procedures	100% of Schedule	100% of Schedule
Type 3 Procedures	100% of Schedule	100% of Schedule

When a Participating Provider is used:	
Maximum Amount - Each Benefit Period	\$2,500

When a Non-Participating Provider is used:	
Maximum Amount - Each Benefit Period	\$2,500

Family Maximum - Each Benefit Period	\$6,000
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**ORTHODONTIC EXPENSE BENEFITS**

Deductible Amount - Once per lifetime	\$0
Benefit Percentage	100%
Maximum Benefit During Lifetime	\$3,000

## DEFINITIONS

**COMPANY** refers to Ameritas Life Insurance Corp. of New York. The words "we", "us" and "our" refer to Company. Our Home Office address is 1350 Broadway, Suite 2201, New York, NY 10018.

**PLANHOLDER** refers to the Planholder stated on the face page of this document.

**MEMBER** refers to a person:

- a. who is a Member of the eligible class; and
- b. who has qualified for coverage by completing the eligibility period, if any; and
- c. for whom the coverage has become effective.

**DOMESTIC PARTNER.** Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

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

**DEPENDENT** refers to:

- a. a Member's spouse or Domestic Partner.
- b. each child less than 26 years of age, for whom the Member, the Member's spouse, or the Member's Domestic Partner, is legally responsible, or is eligible under the federal laws identified below, including:
  - i. natural born children;
  - ii. adopted children, eligible from the date of placement for adoption;
  - iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

Spouses of Dependents and children of Dependents may not be enrolled under this plan. Additionally, if the Planholder's separate medical plans are considered to have "grandfathered status" as defined in the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, Dependents may not be eligible Dependents under such medical plans if they are eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent for plan years beginning before January 1, 2014. Dependents that are ineligible under the Planholder's separate medical plans will be ineligible under this Plan as well.

- c. each child age 26 or older who:
  - i. is Totally Disabled as defined below; and
  - ii. becomes Totally Disabled while covered as a dependent under b. above.

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

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

**TOTAL DISABILITY** describes the Member's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental or physical handicap; and
2. Chiefly dependent upon the Member for support and maintenance.

**DEPENDENT UNIT** refers to all of the people who are covered as the dependents of any one Member.

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

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

**LATE ENTRANT** refers to any person:

- a. whose Effective Date of coverage is more than 31 days from the date the person becomes eligible for coverage; or
- b. who has elected to become covered again after canceling a fee contribution agreement.

**PLAN EFFECTIVE DATE** refers to the date coverage under the plan becomes effective. The Plan Effective Date for the Planholder is July 1, 2017. The effective date of coverage for a Member is shown in the Planholder's records.

All coverage 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 Member.

## CONDITIONS FOR 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 coverage on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Member."

If employment is the basis for membership, a member of the Eligible Class for Coverage is any eligible employee electing dental working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

Late Enrollees Have Limited Coverage For 2 Years are excluded from the Eligible Class for Coverage.

**ELIGIBLE CLASS FOR DEPENDENT COVERAGE.** Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Coverage under the plan and will qualify for this Dependent Coverage 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. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2<sup>nd</sup> birthday. The child may be added at birth or within 31 days of the 2<sup>nd</sup> birthday.

A Member must be covered to also cover his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Coverage is any eligible employee electing dental working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Coverage is as defined by the Planholder.

Late Enrollees Have Limited Coverage For 2 Years are excluded from the Eligible Class for Dependent Coverage.

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

**CONTRIBUTION REQUIREMENTS.** Member Coverage: A Member is not required to contribute to the payment of his or her coverage fees.

Dependent Coverage: A Member is not required to contribute to the payment of coverage fees for his or her dependents.

**ELIGIBILITY PERIOD.** For Members on the Plan Effective Date of the plan, qualification will occur following the eligibility period of 12 month(s) of continuous active employment.

For persons who become Members after the Plan Effective Date of the plan, qualification will occur following the eligibility period of 12 month(s) of continuous active employment.

If employment is the basis for membership in the Eligible Class for Members, a Member 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 coverage.

**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 covered and covering his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the coverage fees. The Effective Date for each Member and his or her Dependents, will be the:

1. the date on which the Member qualifies for coverage, 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 coverage.
3. the date we accept the Member and/or Dependent for coverage when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

**EXCEPTIONS.** If employment is the basis for membership, a Member must be in active service on the date the coverage, or any increase in coverage, is to take effect. If not, the coverage 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 coverage, or any increase in coverage, is to take effect. The coverage will not take effect until the day after he or she ceases to be totally disabled.

## **TERMINATION DATES**

**MEMBERS.** The coverage for any Member, will automatically terminate on the **earliest of:**

1. the date the Member ceases to be a Member;
2. the last day of the period for which the Member has contributed, if required, to the payment of coverage fees; or
3. the date the plan is terminated.

**DEPENDENTS.** The coverage for all of a Member's dependents will automatically terminate on the **earliest of:**

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

The coverage 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."



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

## DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group plan for dental expenses incurred by a Member. A Covered person has the freedom of choice to receive treatment from any Provider.

**DETERMINING BENEFITS.** The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Benefit 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 Covered 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 a Member.

**COVERED EXPENSES.** Covered Expenses include:

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

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

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

1. the actual charge of the Provider.
2. the Maximum Allowable Charge ("MAC") as covered under your plan.
3. the Maximum Covered Expense as covered under your plan.

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

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

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

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

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

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

1. in the first 6 months that a person is covered if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
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.

unless such appliance, restoration or procedure is considered medically necessary.

3. for any procedure begun after the covered person's coverage under this plan terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Member's coverage under this Plan 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 plan, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
8. for which the Covered person is entitled to benefits under any worker'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 Covered person is not liable or which would not have been made had no coverage 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.**

- Your benefits are based on a Benefit Year. A Benefit Year runs from September 1 through August 31.
- Benefit Period means the period from September 1 of any year through August 31 of the next year. But during the first year a person is covered, a benefit period means the period from his or her effective date through August 31 of the next year.
- 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.
- Radiographic images, periodontal charting and supporting diagnostic data may be requested for our review.
- B/R means By Report.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our Member.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

**TYPE 1 PROCEDURES**  
**PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Maximum Covered Expense**  
**For Additional Limitations - See Limitations**

	Maximum Covered Expense
<b>ROUTINE ORAL EVALUATION</b>	
D0120 Periodic oral evaluation - established patient.	\$32.00
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.	\$36.00
D0150 Comprehensive oral evaluation - new or established patient.	\$35.00
D0180 Comprehensive periodontal evaluation - new or established patient.	\$32.00
<b>COMPREHENSIVE EVALUATION: D0150, D0180</b>	
Coverage is limited to 1 of each of these procedures per provider.	
In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per Plan Year.	
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.	
<b>ROUTINE EVALUATION: D0120, D0145</b>	
Coverage is limited to 2 of any of these procedures per Plan Year.	
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.	
<b>COMPLETE SERIES OR PANORAMIC</b>	
D0210 Intraoral - comprehensive series of radiographic images.	\$50.00
D0330 Panoramic radiographic image.	\$45.00
<b>COMPLETE SERIES/PANORAMIC: D0210, D0330</b>	
Coverage is limited to 1 of any of these procedures per 3 year(s).	
<b>OTHER XRAYS</b>	
D0220 Intraoral - periapical first radiographic image.	\$9.00
D0230 Intraoral - periapical each additional radiographic image.	\$7.00
D0240 Intraoral - occlusal radiographic image.	\$15.00
D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.	\$16.00
D0251 Extra-oral posterior dental radiographic image.	\$16.00
<b>PERIAPICAL: D0220, D0230</b>	
The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.	
<b>BITEWINGS</b>	
D0270 Bitewing - single radiographic image.	\$8.00
D0272 Bitewings - two radiographic images.	\$15.00
D0273 Bitewings - three radiographic images.	\$19.00
D0274 Bitewings - four radiographic images.	\$24.00
D0277 Vertical bitewings - 7 to 8 radiographic images.	\$33.00
<b>BITEWINGS: D0270, D0272, D0273, D0274</b>	
Coverage is limited to 2 of any of these procedures per Plan Year.	
D0277, also contribute(s) to this limitation.	
The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.	
<b>VERTICAL BITEWINGS: D0277</b>	
Coverage is limited to 1 of any of these procedures per 3 year(s).	
The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.	
<b>PROPHYLAXIS (CLEANING) AND FLUORIDE</b>	
D1110 Prophylaxis - adult.	\$55.00
D1120 Prophylaxis - child.	\$25.00
D1206 Topical application of fluoride varnish.	\$25.00
D1208 Topical application of fluoride-excluding varnish.	\$25.00

## TYPE 1 PROCEDURES

Maximum Covered  
Expense

D9932	Cleaning and inspection of removable complete denture, maxillary.	\$44.00
D9933	Cleaning and inspection of removable complete denture, mandibular.	\$44.00
D9934	Cleaning and inspection of removable partial denture, maxillary.	\$44.00
D9935	Cleaning and inspection of removable partial denture, mandibular.	\$44.00

FLUORIDE: D1206, D1208

Coverage is limited to 1 of any of these procedures per Plan Year.

Benefits are considered for persons age 13 and under.

PROPHYLAXIS: D1110, D1120

Coverage is limited to 2 of any of these procedures per Plan Year.

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.

CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935

Coverage is limited to 2 of any of these procedures per Plan Year.

Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

### SPACE MAINTAINERS

D1510	Space maintainer-fixed, unilateral-per quadrant.	\$145.00
D1516	Space maintainer - fixed - bilateral, maxillary.	\$225.00
D1517	Space maintainer - fixed - bilateral, mandibular.	\$225.00
D1520	Space maintainer-removable, unilateral-per quadrant.	\$130.00
D1526	Space maintainer - removable - bilateral, maxillary.	\$230.00
D1527	Space maintainer - removable - bilateral, mandibular.	\$230.00
D1551	Re-cement or re-bond bilateral space maintainer-maxillary.	\$30.00
D1552	Re-cement or re-bond bilateral space maintainer-mandibular.	\$30.00
D1553	Re-cement or re-bond unilateral space maintainer-per quadrant.	\$30.00
D1556	Removal of fixed unilateral space maintainer-per quadrant.	\$30.00
D1557	Removal of fixed bilateral space maintainer-maxillary.	\$30.00
D1558	Removal of fixed bilateral space maintainer-mandibular.	\$30.00
D1575	Distal shoe space maintainer - fixed, unilateral-per quadrant.	\$132.00

SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527, D1575

Benefits are considered for persons age 15 and under.

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.	\$500.00
D8220	Fixed appliance therapy.	\$500.00

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

### NON-SURGICAL MISCELLANEOUS

D0160	Detailed and extensive oral evaluation - problem focused, by report.	\$38.00
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**TYPE 2 PROCEDURES**  
**PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Maximum Covered Expense**  
**For Additional Limitations - See Limitations**

	Maximum Covered Expense
<b>LIMITED ORAL EVALUATION</b>	
D0140 Limited oral evaluation - problem focused.	\$33.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$25.00
LIMITED ORAL EVALUATION: D0140, D0170	
Coverage is limited to 2 of any of these procedures per Plan Year.	
<b>ORAL PATHOLOGY/LABORATORY</b>	
D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$43.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$87.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$143.00
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.	
<b>SEALANTS AND CARIES MEDICAMENTS</b>	
D1351 Sealant - per tooth.	\$22.00
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.	\$26.00
D1353 Sealant repair - per tooth.	\$21.00
D1354 Application of caries arresting medicament-per tooth.	B/R
D1355 Caries preventive medicament application - per tooth.	B/R
SEALANT: D1351, D1352, D1353	
Coverage is limited to 1 of any of these procedures per 3 year(s).	
D1354, D1355, also contribute(s) to this limitation.	
Benefits are considered for persons age 15 and under.	
Benefits are considered on permanent molars only.	
Coverage is allowed on the occlusal surface only.	
<b>AMALGAM RESTORATIONS (FILLINGS)</b>	
D2140 Amalgam - one surface, primary or permanent.	\$45.00
D2150 Amalgam - two surfaces, primary or permanent.	\$55.00
D2160 Amalgam - three surfaces, primary or permanent.	\$70.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$80.00
AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161	
Coverage is limited to 1 of any of these procedures per 6 month(s).	
D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.	
<b>RESIN RESTORATIONS (FILLINGS)</b>	
D2330 Resin-based composite - one surface, anterior.	\$50.00
D2331 Resin-based composite - two surfaces, anterior.	\$65.00
D2332 Resin-based composite - three surfaces, anterior.	\$85.00
D2335 Resin-based composite - four or more surfaces (anterior).	\$110.00
D2391 Resin-based composite - one surface, posterior.	\$110.00
D2392 Resin-based composite - two surfaces, posterior.	\$130.00
D2393 Resin-based composite - three surfaces, posterior.	\$150.00
D2394 Resin-based composite - four or more surfaces, posterior.	\$165.00
D2410 Gold foil - one surface.	\$58.00
D2420 Gold foil - two surfaces.	\$159.00
D2430 Gold foil - three surfaces.	\$275.00
D2990 Resin infiltration of incipient smooth surface lesions.	\$132.00
COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990	
Coverage is limited to 1 of any of these procedures per 6 month(s).	
D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.	

## TYPE 2 PROCEDURES

Maximum Covered  
Expense

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.	\$100.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth.	\$100.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth.	\$100.00
D2930	Prefabricated stainless steel crown - primary tooth.	\$110.00
D2931	Prefabricated stainless steel crown - permanent tooth.	\$110.00
D2932	Prefabricated resin crown.	\$110.00
D2933	Prefabricated stainless steel crown with resin window.	\$118.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	\$157.00

### STAINLESS STEEL CROWN: D2390, D2928, D2929, D2930, D2931, D2932, D2933, D2934

Replacement is limited to 1 of any of these procedures per 12 month(s).

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

### RECEMENT

D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.	\$39.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core.	\$34.00
D2920	Re-cement or re-bond crown.	\$39.00
D2921	Reattachment of tooth fragment, incisal edge or cusp.	\$117.00
D6092	Re-cement or re-bond implant/abutment supported crown.	\$51.00
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture.	\$91.00
D6930	Re-cement or re-bond fixed partial denture.	\$50.00

### SEDATIVE FILLING

D2940	Protective restoration.	\$40.00
D2941	Interim therapeutic restoration - primary dentition.	\$47.00
D2991	Application of hydroxyapatite regeneration medicament - per tooth.	\$22.00

### PULP CAP

D3110	Pulp cap - direct (excluding final restoration).	\$36.00
D3120	Pulp cap - indirect (excluding final restoration).	\$29.00

### ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$87.00
D3221	Pulpal debridement, primary and permanent teeth.	\$55.00
D3222	Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.	\$113.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$143.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$99.00
D3333	Internal root repair of perforation defects.	\$182.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).	\$173.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).	\$99.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	\$253.00
D3357	Pulpal regeneration - completion of treatment.	\$266.00
D3430	Retrograde filling - per root.	\$126.00
D3450	Root amputation - per root.	\$257.00
D3920	Hemisection (including any root removal), not including root canal therapy.	\$201.00
D3921	Decoronation or submergence of an erupted tooth.	\$90.00

### ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920, D3921

Procedure D3333 is limited to permanent teeth only.

### ENDODONTIC THERAPY (ROOT CANALS)



## TYPE 2 PROCEDURES

	Maximum Covered Expense
D3310 Endodontic therapy, anterior tooth.	\$366.00
D3320 Endodontic therapy, premolar tooth (excluding final restorations).	\$447.00
D3330 Endodontic therapy, molar tooth (excluding final restorations).	\$577.00
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$236.00
D3346 Retreatment of previous root canal therapy - anterior.	\$493.00
D3347 Retreatment of previous root canal therapy - premolar.	\$581.00
D3348 Retreatment of previous root canal therapy - molar.	\$699.00

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

Coverage is limited to 1 of any of these procedures per 12 month(s).

D3310, D3320, D3330, also contribute(s) to this limitation.

Benefits are considered on permanent teeth only.

Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

### SURGICAL ENDODONTICS

D3355 Pulpal regeneration - initial visit.	\$165.00
D3356 Pulpal regeneration - interim medication replacement.	\$93.00
D3410 Apicoectomy - anterior.	\$419.00
D3421 Apicoectomy - premolar (first root).	\$458.00
D3425 Apicoectomy - molar (first root).	\$518.00
D3426 Apicoectomy (each additional root).	\$173.00
D3471 Surgical repair of root resorption - anterior.	\$343.00
D3472 Surgical repair of root resorption - premolar.	\$347.00
D3473 Surgical repair of root resorption - molar.	\$350.00
D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.	\$170.00
D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.	\$173.00
D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.	\$176.00

### SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$335.00
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$143.00
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth.	\$143.00
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$494.00
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$328.00
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.	\$638.00
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.	\$523.00
D4263 Bone replacement graft - retained natural tooth - first site in quadrant.	\$241.00
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.	\$150.00
D4265 Biologic materials to aid in soft and osseous tissue regeneration, per site.	\$280.00
D4266 Guided tissue regeneration, natural teeth - resorbable barrier, per site.	\$325.00
D4267 Guided tissue regeneration, natural teeth - non-resorbable barrier, per site.	\$374.00
D4270 Pedicle soft tissue graft procedure.	\$472.00
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.	\$518.00
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).	\$183.00
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.	\$518.00
D4276 Combined connective tissue and pedicle graft, per tooth.	\$506.00

## TYPE 2 PROCEDURES

	Maximum Covered Expense
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.	\$485.00
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.	\$240.00
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.	\$518.00
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.	\$518.00
D4286 Removal of non-resorbable barrier.	\$90.00
BONE GRAFTS: D4263, D4264, D4265	
Each quadrant is limited to 1 of any of these procedures per day(s).	
D4210, D4211, D4212, D4240, D4241, D4260, D4261, D4266, D4267, D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285, D4286, also contribute(s) to this limitation.	
Coverage is limited to treatment of periodontal disease.	
DISTAL WEDGE: D4274	
Each quadrant is limited to 1 of any of these procedures per day(s).	
D4210, D4211, D4212, D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285, D4286, also contribute(s) to this limitation.	
Coverage is limited to treatment of periodontal disease.	
GINGIVECTOMY: D4210, D4211, D4212	
Each quadrant is limited to 1 of any of these procedures per day(s).	
D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285, D4286, also contribute(s) to this limitation.	
Coverage is limited to treatment of periodontal disease.	
GUIDED TISSUE REGENERATION: D4266, D4267, D4286	
Each quadrant is limited to 1 of any of these procedures per day(s).	
D4210, D4211, D4212, D4240, D4241, D4260, D4261, also contribute(s) to this limitation.	
Coverage is limited to treatment of periodontal disease.	
OSSEOUS SURGERY: D4240, D4241, D4260, D4261	
Each quadrant is limited to 1 of any of these procedures per day(s).	
D4210, D4211, D4212, D4263, D4264, D4265, D4266, D4267, D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285, D4286, also contribute(s) to this limitation.	
Coverage is limited to treatment of periodontal disease.	
TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285	
Each quadrant is limited to 1 of any of these procedures per day(s).	
D4210, D4211, D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4274, D4286, also contribute(s) to this limitation.	
Coverage is limited to treatment of periodontal disease.	
NON-SURGICAL PERIODONTICS	
D4322 Splint-intra-coronal; natural teeth or prosthetic crowns.	\$233.00
D4323 Splint-extra-coronal; natural teeth or prosthetic crowns.	\$205.00
D4341 Periodontal scaling and root planing - four or more teeth per quadrant.	\$127.00
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.	\$31.00
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	\$80.00
ANTIMICROBIAL AGENTS: D4381	
Each quadrant is limited to 2 of any of these procedures per 2 year(s).	
PERIODONTAL SCALING & ROOT PLANING: D4341, D4342	
Each quadrant is limited to 1 of each of these procedures per 2 year(s).	
FULL MOUTH DEBRIDEMENT	
D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.	\$84.00
FULL MOUTH DEBRIDEMENT: D4355	

## TYPE 2 PROCEDURES

Maximum Covered  
Expense

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

### PERIODONTAL MAINTENANCE

D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation. \$20.00

D4910 Periodontal maintenance. \$76.00

PERIODONTAL MAINTENANCE: D4346, D4910

Benefits are not available if performed on the same date as any other periodontal service.

Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.

Procedure D4346 is limited to persons age 14 and over.

### NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - primary tooth. \$70.00

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal). \$90.00

### SURGICAL EXTRACTIONS

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated. \$143.00

D7220 Removal of impacted tooth - soft tissue. \$179.00

D7230 Removal of impacted tooth - partially bony. \$238.00

D7240 Removal of impacted tooth - completely bony. \$280.00

D7241 Removal of impacted tooth - completely bony, with unusual surgical complications. \$352.00

D7250 Removal of residual tooth roots (cutting procedure). \$150.00

D7251 Coronectomy - intentional partial tooth removal, impacted teeth only. \$248.00

### OTHER ORAL SURGERY

D7260 Oroantral fistula closure. \$500.00

D7261 Primary closure of a sinus perforation. \$352.00

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth. \$300.00

D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization). \$315.00

D7280 Exposure of an unerupted tooth. \$337.00

D7282 Mobilization of erupted or malpositioned tooth to aid eruption. \$221.00

D7283 Placement of device to facilitate eruption of impacted tooth. \$128.00

D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. \$133.00

D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant. \$99.00

D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. \$250.00

D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant. \$125.00

D7340 Vestibuloplasty - ridge extension (secondary epithelialization). \$464.00

D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue). \$730.00

D7410 Excision of benign lesion up to 1.25 cm. \$190.00

D7411 Excision of benign lesion greater than 1.25 cm. \$297.00

D7412 Excision of benign lesion, complicated. \$549.00

D7413 Excision of malignant lesion up to 1.25 cm. \$235.00

D7414 Excision of malignant lesion greater than 1.25 cm. \$357.00

D7415 Excision of malignant lesion, complicated. \$511.00

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. \$390.00

D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm. \$429.00

D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm. \$956.00

D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm. \$281.00

D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm. \$427.00

D7465 Destruction of lesion(s) by physical or chemical method, by report. \$169.00

D7471 Removal of lateral exostosis (maxilla or mandible). \$494.00

D7472 Removal of torus palatinus. \$362.00

## TYPE 2 PROCEDURES

	Maximum Covered Expense
D7473 Removal of torus mandibularis.	\$324.00
D7485 Reduction of osseous tuberosity.	\$487.00
D7490 Radical resection of maxilla or mandible.	\$1296.00
D7509 Marsupialization of odontogenic cyst.	\$159.00
D7510 Incision and drainage of abscess - intraoral soft tissue.	\$159.00
D7511 Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces).	\$196.00
D7520 Incision and drainage of abscess - extraoral soft tissue.	\$410.00
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$226.00
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.	\$291.00
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.	\$246.00
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.	\$1287.00
D7910 Suture of recent small wounds up to 5 cm.	\$271.00
D7911 Complicated suture - up to 5 cm.	\$282.00
D7912 Complicated suture - greater than 5 cm.	\$595.00
D7961 Buccal/labial frenectomy (frenulectomy).	\$350.00
D7962 Lingual frenectomy (frenulectomy).	\$350.00
D7963 Frenuloplasty.	\$535.00
D7970 Excision of hyperplastic tissue - per arch.	\$155.00
D7972 Surgical reduction of fibrous tuberosity.	\$152.00
D7979 Non-surgical sialolithotomy.	\$120.00
D7980 Surgical sialolithotomy.	\$240.00
D7983 Closure of salivary fistula.	\$239.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

### BIOPSY OF ORAL TISSUE

D7285 Incisional biopsy of oral tissue - hard (bone, tooth).	\$250.00
D7286 Incisional biopsy of oral tissue - soft.	\$175.00
D7287 Exfoliative cytological sample collection.	\$53.00
D7288 Brush biopsy - transepithelial sample collection.	\$66.00

### PALLIATIVE

D9110 Palliative treatment of dental pain - per visit.	\$35.00
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PALLIATIVE TREATMENT: D9110

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

### ANESTHESIA-GENERAL/IV

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.	\$21.00
D9222 Deep sedation/general anesthesia - first 15 minutes.	\$55.00
D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.	\$55.00
D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.	\$55.00
D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.	\$55.00

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

Coverage is only available with a cutting procedure. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

### PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.	\$45.00
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.	\$21.00
D9440 Office visit - after regularly scheduled hours.	\$46.00
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.	\$34.00

CONSULTATION: D9310

Coverage is limited to 1 of any of these procedures per 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.	\$60.00
D9952	Occlusal adjustment - complete.	\$175.00
OCCLUSAL ADJUSTMENT: D9951, D9952		
Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.		
MISCELLANEOUS		
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	\$135.00
D2951	Pin retention - per tooth, in addition to restoration.	\$25.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$25.00
DESENSITIZATION: D9911		
Coverage is limited to 1 of any of these procedures per 6 month(s).		
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.		
Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.		

**TYPE 3 PROCEDURES**  
**PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Maximum Covered Expense**  
**For Additional Limitations - See Limitations**

	Maximum Covered Expense
<b>INLAY RESTORATIONS</b>	
D2510 Inlay - metallic - one surface.	\$245.00
D2520 Inlay - metallic - two surfaces.	\$250.00
D2530 Inlay - metallic - three or more surfaces.	\$375.00
D2610 Inlay - porcelain/ceramic - one surface.	\$250.00
D2620 Inlay - porcelain/ceramic - two surfaces.	\$275.00
D2630 Inlay - porcelain/ceramic - three or more surfaces.	\$325.00
D2650 Inlay - resin-based composite - one surface.	\$150.00
D2651 Inlay - resin-based composite - two surfaces.	\$250.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$275.00

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.

<b>ONLAY RESTORATIONS</b>	
D2542 Onlay - metallic - two surfaces.	\$300.00
D2543 Onlay - metallic - three surfaces.	\$345.00
D2544 Onlay - metallic - four or more surfaces.	\$375.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$325.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$350.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$400.00
D2662 Onlay - resin-based composite - two surfaces.	\$235.00
D2663 Onlay - resin-based composite - three surfaces.	\$275.00
D2664 Onlay - resin-based composite - four or more surfaces.	\$300.00

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, D2753, 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, D6753, D6780, D6781, D6782, D6783, D6784, 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, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

<b>CROWNS SINGLE RESTORATIONS</b>	
D2710 Crown - resin-based composite (indirect).	\$246.00
D2712 Crown - 3/4 resin-based composite (indirect).	\$215.00
D2720 Crown - resin with high noble metal.	\$605.00
D2721 Crown - resin with predominantly base metal.	\$568.00
D2722 Crown - resin with noble metal.	\$580.00
D2740 Crown - porcelain/ceramic.	\$622.00
D2750 Crown - porcelain fused to high noble metal.	\$614.00
D2751 Crown - porcelain fused to predominantly base metal.	\$571.00
D2752 Crown - porcelain fused to noble metal.	\$585.00
D2753 Crown-porcelain fused to titanium and titanium alloys.	\$585.00
D2780 Crown - 3/4 cast high noble metal.	\$704.00
D2781 Crown - 3/4 cast predominantly base metal.	\$541.00
D2782 Crown - 3/4 cast noble metal.	\$664.00
D2783 Crown - 3/4 porcelain/ceramic.	\$655.00
D2790 Crown - full cast high noble metal.	\$592.00

## TYPE 3 PROCEDURES

	Maximum Covered Expense
D2791 Crown - full cast predominantly base metal.	\$561.00
D2792 Crown - full cast noble metal.	\$571.00
D2794 Crown - titanium and titanium alloys.	\$695.00
CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, 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, D6753, D6780, D6781, D6782, D6783, D6784, 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.	
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.	
Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.	
Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. Coverage is limited to necessary placement resulting from decay or traumatic injury.	
<b>CORE BUILD-UP</b>	
D2950 Core buildup, including any pins when required.	\$115.00
CORE BUILDUP: D2950	
A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.	
<b>POST AND CORE</b>	
D2952 Post and core in addition to crown, indirectly fabricated.	\$180.00
D2954 Prefabricated post and core in addition to crown.	\$150.00
<b>VENEERS</b>	
D2960 Labial veneer (resin laminate) - direct.	\$250.00
D2961 Labial veneer (resin laminate) - indirect.	\$335.00
D2962 Labial veneer (porcelain laminate) - indirect.	\$350.00
LABIAL VENEERS: D2960, D2961, D2962	
Replacement is limited to 1 of any of these procedures per 5 year(s).	
Frequency is waived for accidental injury.	
Benefits are considered on anterior teeth only.	
Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.	
<b>FIXED CROWN AND PARTIAL DENTURE REPAIR</b>	
D2980 Crown repair necessitated by restorative material failure.	\$90.00
D2981 Inlay repair necessitated by restorative material failure.	\$90.00
D2982 Onlay repair necessitated by restorative material failure.	\$90.00
D2983 Veneer repair necessitated by restorative material failure.	\$90.00
D6980 Fixed partial denture repair necessitated by restorative material failure.	\$85.00
D9120 Fixed partial denture sectioning.	\$59.00
<b>CROWN LENGTHENING</b>	
D4249 Clinical crown lengthening - hard tissue.	\$398.00
<b>PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)</b>	
D5110 Complete denture - maxillary.	\$600.00
D5120 Complete denture - mandibular.	\$600.00
D5130 Immediate denture - maxillary.	\$679.00
D5140 Immediate denture - mandibular.	\$673.00

### TYPE 3 PROCEDURES

	Maximum Covered Expense
D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).	\$525.00
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).	\$525.00
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).	\$620.00
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).	\$620.00
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).	\$405.00
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).	\$413.00
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).	\$685.00
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).	\$649.00
D5225 Maxillary partial denture-flexible base (including retentive/clasping materials, rests, and teeth).	\$571.00
D5226 Mandibular partial denture-flexible base (including retentive/clasping materials, rests, and teeth).	\$569.00
D5227 Immediate maxillary partial denture-flexible base (including any clasps, rests and teeth).	\$571.00
D5228 Immediate mandibular partial denture-flexible base (including any clasps, rests and teeth).	\$569.00
D5282 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.	\$267.00
D5283 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.	\$267.00
D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth)-per quadrant.	\$267.00
D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth)-per quadrant.	\$267.00
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).	\$205.00
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).	\$180.00
D5810 Interim complete denture (maxillary).	\$353.00
D5811 Interim complete denture (mandibular).	\$342.00
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.	\$209.00
D5821 Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular.	\$199.00
D5863 Overdenture - complete maxillary.	\$1162.00
D5864 Overdenture - partial maxillary.	\$697.00
D5865 Overdenture - complete mandibular.	\$1115.00
D5866 Overdenture - partial mandibular.	\$811.00
D5876 Add metal substructure to acrylic full denture (per arch).	\$198.00
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.	\$1772.00
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.	\$1930.00
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.	\$911.00
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.	\$846.00
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.	\$1441.00
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.	\$1441.00
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.	\$721.00
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.	\$739.00
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.	\$342.00
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.	\$353.00
COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D5876, D6110, D6111, D6114, D6115	
Replacement is limited to 1 of any of these procedures per 5 year(s).	
Frequency is waived for accidental injury.	
Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.	
PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5227, D5228, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117	



### TYPE 3 PROCEDURES

Maximum Covered  
Expense

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

D6010, D6040, D6050, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

#### DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	\$25.00
D5411	Adjust complete denture - mandibular.	\$35.00
D5421	Adjust partial denture - maxillary.	\$35.00
D5422	Adjust partial denture - mandibular.	\$30.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

Each arch is limited to 1 of any of these procedures per 3 year(s).

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

#### DENTURE REPAIR

D5511	Repair broken complete denture base, mandibular.	\$75.00
D5512	Repair broken complete denture base, maxillary.	\$75.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	\$70.00
D5611	Repair resin partial denture base, mandibular.	\$70.00
D5612	Repair resin partial denture base, maxillary.	\$70.00
D5621	Repair cast partial framework, mandibular.	\$75.00
D5622	Repair cast partial framework, maxillary.	\$75.00
D5630	Repair or replace broken retentive/clasping materials per tooth.	\$85.00
D5640	Replace broken teeth - per tooth.	\$70.00

#### ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	\$80.00
D5660	Add clasp to existing partial denture-per tooth.	\$100.00

#### DENTURE REBASES

D5710	Rebase complete maxillary denture.	\$125.00
D5711	Rebase complete mandibular denture.	\$125.00
D5720	Rebase maxillary partial denture.	\$125.00
D5721	Rebase mandibular partial denture.	\$125.00
D5725	Rebase hybrid prosthesis.	\$100.00

DENTURE REBASE: D5710, D5711, D5720, D5721, D5725, D5765

Each arch is limited to 1 of any of these procedures per 3 year(s).

D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, also contribute(s) to this limitation.

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

#### DENTURE RELINES

D5730	Reline complete maxillary denture (direct).	\$140.00
D5731	Reline complete mandibular denture (direct).	\$140.00
D5740	Reline maxillary partial denture (direct).	\$85.00
D5741	Reline mandibular partial denture (direct).	\$85.00
D5750	Reline complete maxillary denture (indirect).	\$150.00
D5751	Reline complete mandibular denture (indirect).	\$150.00
D5760	Reline maxillary partial denture (indirect).	\$145.00
D5761	Reline mandibular partial denture (indirect).	\$145.00
D5765	Soft liner for complete or partial removable denture-indirect.	\$150.00

DENTURE REBASE: D5710, D5711, D5720, D5721, D5725, D5765

Each arch is limited to 1 of any of these procedures per 3 year(s).

D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, also contribute(s) to this limitation.

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

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5765

## TYPE 3 PROCEDURES

Maximum Covered  
Expense

Each arch is limited to 1 of any of these procedures per 3 year(s).  
D5710, D5711, D5720, D5721, D5725, also contribute(s) to this limitation.  
Coverage is limited to service dates more than 6 months after placement date.

### TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	\$66.00
D5851	Tissue conditioning, mandibular.	\$76.00

### IMPLANTS

D6010	Surgical placement of implant body: endosteal implant.	\$1000.00
D6040	Surgical placement: eposteal implant.	\$1000.00
D6050	Surgical placement: transosteal implant.	\$1000.00
D6051	Interim implant abutment placement.	\$143.00
D6055	Connecting bar-implant supported or abutment supported.	\$1109.00
D6056	Prefabricated abutment - includes placement.	\$250.00
D6057	Custom abutment - includes placement.	\$300.00
D6191	Semi-precision abutment-placement.	\$293.00
D6192	Semi-precision attachment-placement.	\$293.00

IMPLANT: D6010, D6040, D6050

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

D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284, D5286, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Benefits for procedures D6051, D6055, D6056, D6057, D6191 and D6192 will be contingent upon the implant being covered. Replacement for procedures D6056, D6057, D6191 and D6192 are limited to 1 of any of these procedures in 5 years.

### IMPLANT SERVICES

D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments.	\$77.00
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.	\$10.00
D6089	Accessing and retorquing loose implant screw - per screw.	\$50.00
D6090	Repair implant supported prosthesis, by report.	\$100.00
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment.	\$123.00
D6095	Repair implant abutment, by report.	\$271.00
D6096	Remove broken implant retaining screw.	\$100.00
D6100	Surgical removal of implant body.	\$500.00
D6105	Removal of implant body not requiring bone removal nor flap elevation.	\$90.00
D6190	Radiographic/surgical implant index, by report.	\$146.00
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.	\$50.00
D6198	Remove interim implant component.	\$350.00

IMPLANT SERVICES: D6080, D6081, D6089, D6090, D6091, D6095, D6096, D6100, D6105, D6190, D6197, D6198

Coverage for D6080 and D6081 is limited to 2 of any of these procedures in a 12 month period.

Coverage for D6089, D6090, D6091, D6095 and D6096 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

### PROSTHODONTICS - FIXED

D6058	Abutment supported porcelain/ceramic crown.	\$700.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	\$400.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	\$700.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	\$700.00
D6062	Abutment supported cast metal crown (high noble metal).	\$681.00
D6063	Abutment supported cast metal crown (predominantly base metal).	\$503.00
D6064	Abutment supported cast metal crown (noble metal).	\$516.00
D6065	Implant supported porcelain/ceramic crown.	\$687.00

## TYPE 3 PROCEDURES

	Maximum Covered Expense
D6066	Implant supported crown - porcelain fused to high noble alloys. \$650.00
D6067	Implant supported crown - high noble alloys. \$702.00
D6068	Abutment supported retainer for porcelain/ceramic FPD. \$687.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal). \$645.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal). \$607.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal). \$615.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal). \$702.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal). \$488.00
D6074	Abutment supported retainer for cast metal FPD (noble metal). \$586.00
D6075	Implant supported retainer for ceramic FPD. \$687.00
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys. \$645.00
D6077	Implant supported retainer for metal FPD - high noble alloy. \$702.00
D6082	Implant supported crown-porcelain fused to predominantly base alloys. \$563.00
D6083	Implant supported crown-porcelain fused to noble alloys. \$618.00
D6084	Implant supported crown-porcelain fused to titanium and titanium alloys. \$618.00
D6086	Implant supported crown-predominantly base alloys. \$563.00
D6087	Implant supported crown-noble alloys. \$618.00
D6088	Implant supported crown-titanium and titanium alloys. \$618.00
D6094	Abutment supported crown - titanium and titanium alloys. \$568.00
D6097	Abutment supported crown-porcelain fused to titanium and titanium alloys. \$630.00
D6098	Implant supported retainer-porcelain fused to predominantly base alloys. \$563.00
D6099	Implant supported retainer for FPD-porcelain fused to noble alloys. \$618.00
D6120	Implant supported retainer-porcelain fused to titanium and titanium alloys. \$618.00
D6121	Implant supported retainer for metal FPD-predominantly base alloys. \$563.00
D6122	Implant supported retainer for metal FPD-noble alloys. \$618.00
D6123	Implant supported retainer for metal FPD-titanium and titanium alloys. \$618.00
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys. \$492.00
D6195	Abutment supported retainer-porcelain fused to titanium and titanium alloys. \$618.00
D6205	Pontic - indirect resin based composite. \$417.00
D6210	Pontic - cast high noble metal. \$443.00
D6211	Pontic - cast predominantly base metal. \$514.00
D6212	Pontic - cast noble metal. \$535.00
D6214	Pontic - titanium and titanium alloys. \$614.00
D6240	Pontic - porcelain fused to high noble metal. \$542.00
D6241	Pontic - porcelain fused to predominantly base metal. \$501.00
D6242	Pontic - porcelain fused to noble metal. \$528.00
D6243	Pontic-porcelain fused to titanium and titanium alloys. \$527.00
D6245	Pontic - porcelain/ceramic. \$586.00
D6250	Pontic - resin with high noble metal. \$535.00
D6251	Pontic - resin with predominantly base metal. \$494.00
D6252	Pontic - resin with noble metal. \$509.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis. \$180.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis. \$521.00
D6549	Resin retainer - for resin bonded fixed prosthesis. \$459.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces. \$448.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces. \$477.00
D6602	Retainer inlay - cast high noble metal, two surfaces. \$299.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces. \$473.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces. \$275.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces. \$425.00
D6606	Retainer inlay - cast noble metal, two surfaces. \$334.00
D6607	Retainer inlay - cast noble metal, three or more surfaces. \$464.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces. \$463.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces. \$656.00
D6610	Retainer onlay - cast high noble metal, two surfaces. \$442.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces. \$297.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces. \$341.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces. \$474.00
D6614	Retainer onlay - cast noble metal, two surfaces. \$342.00
D6615	Retainer onlay - cast noble metal, three or more surfaces. \$491.00

## TYPE 3 PROCEDURES

	Maximum Covered Expense
D6624 Retainer inlay - titanium.	\$501.00
D6634 Retainer onlay - titanium.	\$695.00
D6710 Retainer crown - indirect resin based composite.	\$379.00
D6720 Retainer crown - resin with high noble metal.	\$605.00
D6721 Retainer crown - resin with predominantly base metal.	\$568.00
D6722 Retainer crown - resin with noble metal.	\$585.00
D6740 Retainer crown - porcelain/ceramic.	\$350.00
D6750 Retainer crown - porcelain fused to high noble metal.	\$614.00
D6751 Retainer crown - porcelain fused to predominantly base metal.	\$568.00
D6752 Retainer crown - porcelain fused to noble metal.	\$585.00
D6753 Retainer crown-porcelain fused to titanium and titanium alloys.	\$315.00
D6780 Retainer crown - 3/4 cast high noble metal.	\$585.00
D6781 Retainer crown - 3/4 cast predominantly base metal.	\$508.00
D6782 Retainer crown - 3/4 cast noble metal.	\$555.00
D6783 Retainer crown - 3/4 porcelain/ceramic.	\$675.00
D6784 Retainer crown 3/4-titanium and titanium alloys.	\$607.00
D6790 Retainer crown - full cast high noble metal.	\$592.00
D6791 Retainer crown - full cast predominantly base metal.	\$561.00
D6792 Retainer crown - full cast noble metal.	\$571.00
D6794 Retainer crown - titanium and titanium alloys.	\$583.00
D6940 Stress breaker.	\$99.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, 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, D2753, 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.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, 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, D6753, D6780, D6781, D6782, D6783, D6784, 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.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12.

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

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, 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, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

## TYPE 3 PROCEDURES

Maximum Covered  
Expense

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

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

**FIXED PARTIAL PONTIC:** D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

**IMPLANT SUPPORTED CROWN:** D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, 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.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

**IMPLANT SUPPORTED RETAINER:** D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, 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.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

### BONE AUGMENTATION

D6104	Bone graft at time of implant placement.	\$240.00
D6106	Guided tissue regeneration - resorbable barrier, per implant.	\$325.00
D6107	Guided tissue regeneration - non-resorbable barrier, per implant.	\$374.00
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation.	\$146.00
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.	\$215.00
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach.	\$300.00
D7952	Sinus augmentation via a vertical approach.	\$300.00
D7953	Bone replacement graft for ridge preservation - per site.	\$135.00
D7956	Guided tissue regeneration, edentulous area - resorbable barrier, per site.	\$325.00
D7957	Guided tissue regeneration, edentulous area - non-resorbable barrier, per site.	\$374.00

**BONE AUGMENTATION:** D6104, D6106, D6107, D7939, D7950, D7951, D7952, D7953, D7956, D7957

Each quadrant is limited to 1 of any of these procedures per 5 year(s).

Coverage of D6104, D6106, D6107, D7939, D7950, D7951, D7952, D7953, D7956 and D7957 is limited to the treatment and placement of endosteal implant D6010, D6040 eposteal implant or D6050 transosteal implant.

### TYPE 3 PROCEDURES

Maximum Covered  
Expense

MISCELLANEOUS  
D2975 Coping.

\$100.00

**TYPE 1 PROCEDURES**  
**PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge**  
**For Additional Limitations - See Limitations**

**ROUTINE ORAL EVALUATION**

- D0120 Periodic oral evaluation - established patient.
- D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
- D0150 Comprehensive oral evaluation - new or established patient.
- D0180 Comprehensive periodontal evaluation - new or established patient.

**COMPREHENSIVE EVALUATION: D0150, D0180**

Coverage is limited to 1 of each of these procedures per provider.

In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per Plan Year.

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 Plan Year.

D0150, D0180, also contribute(s) to this limitation.

Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

**COMPLETE SERIES OR PANORAMIC**

- D0210 Intraoral - comprehensive series of radiographic images.
- D0330 Panoramic radiographic image.

**COMPLETE SERIES/PANORAMIC: D0210, D0330**

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

**OTHER XRAYS**

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

**PERIAPICAL: D0220, D0230**

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

**BITEWINGS**

- D0270 Bitewing - single radiographic image.
- D0272 Bitewings - two radiographic images.
- D0273 Bitewings - three radiographic images.
- D0274 Bitewings - four radiographic images.
- D0277 Vertical bitewings - 7 to 8 radiographic images.

**BITEWINGS: D0270, D0272, D0273, D0274**

Coverage is limited to 2 of any of these procedures per Plan Year.

D0277, also contribute(s) to this limitation.

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

**VERTICAL BITEWINGS: D0277**

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

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

**PROPHYLAXIS (CLEANING) AND FLUORIDE**

- D1110 Prophylaxis - adult.
- D1120 Prophylaxis - child.
- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride-excluding varnish.
- D9932 Cleaning and inspection of removable complete denture, maxillary.

## TYPE 1 PROCEDURES

D9933 Cleaning and inspection of removable complete denture, mandibular.

D9934 Cleaning and inspection of removable partial denture, maxillary.

D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

Coverage is limited to 1 of any of these procedures per Plan Year.

Benefits are considered for persons age 13 and under.

PROPHYLAXIS: D1110, D1120

Coverage is limited to 2 of any of these procedures per Plan Year.

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.

CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935

Coverage is limited to 2 of any of these procedures per Plan Year.

Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

## SPACE MAINTAINERS

D1510 Space maintainer-fixed, unilateral-per quadrant.

D1516 Space maintainer - fixed - bilateral, maxillary.

D1517 Space maintainer - fixed - bilateral, mandibular.

D1520 Space maintainer-removable, unilateral-per quadrant.

D1526 Space maintainer - removable - bilateral, maxillary.

D1527 Space maintainer - removable - bilateral, mandibular.

D1551 Re-cement or re-bond bilateral space maintainer-maxillary.

D1552 Re-cement or re-bond bilateral space maintainer-mandibular.

D1553 Re-cement or re-bond unilateral space maintainer-per quadrant.

D1556 Removal of fixed unilateral space maintainer-per quadrant.

D1557 Removal of fixed bilateral space maintainer-maxillary.

D1558 Removal of fixed bilateral space maintainer-mandibular.

D1575 Distal shoe space maintainer - fixed, unilateral-per quadrant.

SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527, D1575

Benefits are considered for persons age 15 and under.

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.

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

## NON-SURGICAL MISCELLANEOUS

D0160 Detailed and extensive oral evaluation - problem focused, by report.



**TYPE 2 PROCEDURES**  
**PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge**  
**For Additional Limitations - See Limitations**

**LIMITED ORAL EVALUATION**

- D0140 Limited oral evaluation - problem focused.
  - D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).
- LIMITED ORAL EVALUATION: D0140, D0170
- Coverage is limited to 2 of any of these procedures per Plan Year.

**ORAL PATHOLOGY/LABORATORY**

- D0472 Accession of tissue, gross examination, preparation and transmission of written report.
  - D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
  - D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.
- 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.

**SEALANTS AND CARIES MEDICAMENTS**

- D1351 Sealant - per tooth.
  - D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
  - D1353 Sealant repair - per tooth.
  - D1354 Application of caries arresting medicament-per tooth.
  - D1355 Caries preventive medicament application - per tooth.
- SEALANT: D1351, D1352, D1353
- Coverage is limited to 1 of any of these procedures per 3 year(s).
- D1354, D1355, also contribute(s) to this limitation.
- Benefits are considered for persons age 15 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.
  - D2150 Amalgam - two surfaces, primary or permanent.
  - D2160 Amalgam - three surfaces, primary or permanent.
  - D2161 Amalgam - four or more surfaces, primary or permanent.
- AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161
- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

**RESIN RESTORATIONS (FILLINGS)**

- D2330 Resin-based composite - one surface, anterior.
  - D2331 Resin-based composite - two surfaces, anterior.
  - D2332 Resin-based composite - three surfaces, anterior.
  - D2335 Resin-based composite - four or more surfaces (anterior).
  - D2391 Resin-based composite - one surface, posterior.
  - D2392 Resin-based composite - two surfaces, posterior.
  - D2393 Resin-based composite - three surfaces, posterior.
  - D2394 Resin-based composite - four or more surfaces, posterior.
  - D2410 Gold foil - one surface.
  - D2420 Gold foil - two surfaces.
  - D2430 Gold foil - three surfaces.
  - D2990 Resin infiltration of incipient smooth surface lesions.
- COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990
- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

## TYPE 2 PROCEDURES

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.
- D2928 Prefabricated porcelain/ceramic crown - permanent tooth.
- D2929 Prefabricated porcelain/ceramic crown - primary tooth.
- D2930 Prefabricated stainless steel crown - primary tooth.
- D2931 Prefabricated stainless steel crown - permanent tooth.
- D2932 Prefabricated resin crown.
- D2933 Prefabricated stainless steel crown with resin window.
- D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2928, D2929, D2930, D2931, D2932, D2933, D2934

Replacement is limited to 1 of any of these procedures per 12 month(s).

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

### RECEMENT

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

### SEDATIVE FILLING

- D2940 Protective restoration.
- D2941 Interim therapeutic restoration - primary dentition.
- D2991 Application of hydroxyapatite regeneration medicament - per tooth.

### PULP CAP

- D3110 Pulp cap - direct (excluding final restoration).
- D3120 Pulp cap - indirect (excluding final restoration).

### ENDODONTICS MISCELLANEOUS

- D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
- D3221 Pulpal debridement, primary and permanent teeth.
- D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
- D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
- D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
- D3333 Internal root repair of perforation defects.
- D3351 Apexification/recalcification - initial visit (apical closure/calific repair of perforations, root resorption, etc.).
- D3352 Apexification/recalcification - interim medication replacement (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.).
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.).
- D3357 Pulpal regeneration - completion of treatment.
- D3430 Retrograde filling - per root.
- D3450 Root amputation - per root.
- D3920 Hemisection (including any root removal), not including root canal therapy.
- D3921 Decoronation or submergence of an erupted tooth.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920, D3921

Procedure D3333 is limited to permanent teeth only.

### ENDODONTIC THERAPY (ROOT CANALS)

- D3310 Endodontic therapy, anterior tooth.

## TYPE 2 PROCEDURES

- D3320 Endodontic therapy, premolar tooth (excluding final restorations).
- D3330 Endodontic therapy, molar tooth (excluding final restorations).
- D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
- D3346 Retreatment of previous root canal therapy - anterior.
- D3347 Retreatment of previous root canal therapy - premolar.
- D3348 Retreatment of previous root canal therapy - molar.

### ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

Allowances include intraoperative radiographic images and cultures but exclude final restoration.

### RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

Coverage is limited to 1 of any of these procedures per 12 month(s).

D3310, D3320, D3330, also contribute(s) to this limitation.

Benefits are considered on permanent teeth only.

Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

## SURGICAL ENDODONTICS

- D3355 Pulpal regeneration - initial visit.
- D3356 Pulpal regeneration - interim medication replacement.
- D3410 Apicoectomy - anterior.
- D3421 Apicoectomy - premolar (first root).
- D3425 Apicoectomy - molar (first root).
- D3426 Apicoectomy (each additional root).
- D3471 Surgical repair of root resorption - anterior.
- D3472 Surgical repair of root resorption - premolar.
- D3473 Surgical repair of root resorption - molar.
- D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.
- D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.
- D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.

## SURGICAL PERIODONTICS

- D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth.
- D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
- D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
- D4265 Biologic materials to aid in soft and osseous tissue regeneration, per site.
- D4266 Guided tissue regeneration, natural teeth - resorbable barrier, per site.
- D4267 Guided tissue regeneration, natural teeth - non-resorbable barrier, per site.
- D4270 Pedicle soft tissue graft procedure.
- D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
- D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
- D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
- D4276 Combined connective tissue and pedicle graft, per tooth.
- D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.

## TYPE 2 PROCEDURES

- D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
- D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
- D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
- D4286 Removal of non-resorbable barrier.
- BONE GRAFTS: D4263, D4264, D4265
- Each quadrant is limited to 1 of any of these procedures per day(s).
- D4210, D4211, D4212, D4240, D4241, D4260, D4261, D4266, D4267, D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285, D4286, also contribute(s) to this limitation.
- Coverage is limited to treatment of periodontal disease.
- GINGIVECTOMY: D4210, D4211, D4212
- Each quadrant is limited to 1 of any of these procedures per day(s).
- D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285, D4286, also contribute(s) to this limitation.
- Coverage is limited to treatment of periodontal disease.
- GUIDED TISSUE REGENERATION: D4266, D4267, D4286
- Each quadrant is limited to 1 of any of these procedures per day(s).
- D4210, D4211, D4212, D4240, D4241, D4260, D4261, also contribute(s) to this limitation.
- Coverage is limited to treatment of periodontal disease.
- OSSEOUS SURGERY: D4240, D4241, D4260, D4261
- Each quadrant is limited to 1 of any of these procedures per day(s).
- D4210, D4211, D4212, D4263, D4264, D4265, D4266, D4267, D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285, D4286, also contribute(s) to this limitation.
- Coverage is limited to treatment of periodontal disease.
- TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285
- Each quadrant is limited to 1 of any of these procedures per day(s).
- D4210, D4211, D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4274, D4286, also contribute(s) to this limitation.
- Coverage is limited to treatment of periodontal disease.

## NON-SURGICAL PERIODONTICS

- D4322 Splint-intra-coronal; natural teeth or prosthetic crowns.
- D4323 Splint-extra-coronal; natural teeth or prosthetic crowns.
- D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
- D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.
- D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

### ANTIMICROBIAL AGENTS: D4381

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

### PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

## FULL MOUTH DEBRIDEMENT

- D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.

### FULL MOUTH DEBRIDEMENT: D4355

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

## PERIODONTAL MAINTENANCE

- D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.

- D4910 Periodontal maintenance.

### PERIODONTAL MAINTENANCE: D4346, D4910

## TYPE 2 PROCEDURES

Benefits are not available if performed on the same date as any other periodontal service.  
Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.  
Procedure D4346 is limited to persons age 14 and over.

### NON-SURGICAL EXTRACTIONS

- D7111 Extraction, coronal remnants - primary tooth.
- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

### SURGICAL EXTRACTIONS

- D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
- D7220 Removal of impacted tooth - soft tissue.
- D7230 Removal of impacted tooth - partially bony.
- D7240 Removal of impacted tooth - completely bony.
- D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
- D7250 Removal of residual tooth roots (cutting procedure).
- D7251 Coronectomy - intentional partial tooth removal, impacted teeth only.

### OTHER ORAL SURGERY

- D7260 Oroantral fistula closure.
- D7261 Primary closure of a sinus perforation.
- D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
- D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
- D7280 Exposure of an unerupted tooth.
- D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
- D7283 Placement of device to facilitate eruption of impacted tooth.
- D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
- D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
- D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
- D7410 Excision of benign lesion up to 1.25 cm.
- D7411 Excision of benign lesion greater than 1.25 cm.
- D7412 Excision of benign lesion, complicated.
- D7413 Excision of malignant lesion up to 1.25 cm.
- D7414 Excision of malignant lesion greater than 1.25 cm.
- D7415 Excision of malignant lesion, complicated.
- D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
- D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
- D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
- D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
- D7465 Destruction of lesion(s) by physical or chemical method, by report.
- D7471 Removal of lateral exostosis (maxilla or mandible).
- D7472 Removal of torus palatinus.
- D7473 Removal of torus mandibularis.
- D7485 Reduction of osseous tuberosity.
- D7490 Radical resection of maxilla or mandible.
- D7509 Marsupialization of odontogenic cyst.
- D7510 Incision and drainage of abscess - intraoral soft tissue.
- D7511 Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces).
- D7520 Incision and drainage of abscess - extraoral soft tissue.

## TYPE 2 PROCEDURES

- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
- D7910 Suture of recent small wounds up to 5 cm.
- D7911 Complicated suture - up to 5 cm.
- D7912 Complicated suture - greater than 5 cm.
- D7961 Buccal/labial frenectomy (frenulectomy).
- D7962 Lingual frenectomy (frenulectomy).
- D7963 Frenuloplasty.
- D7970 Excision of hyperplastic tissue - per arch.
- D7972 Surgical reduction of fibrous tuberosity.
- D7979 Non-surgical sialolithotomy.
- D7980 Surgical sialolithotomy.
- D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

### BIOPSY OF ORAL TISSUE

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

### PALLIATIVE

- D9110 Palliative treatment of dental pain - per visit.

PALLIATIVE TREATMENT: D9110

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

### ANESTHESIA-GENERAL/IV

- D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.
- D9222 Deep sedation/general anesthesia - first 15 minutes.
- D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
- D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.
- D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

Coverage is only available with a cutting procedure. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

### PROFESSIONAL CONSULT/VISIT/SERVICES

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

CONSULTATION: D9310

Coverage is limited to 1 of any of these procedures per 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.
- D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

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

### MISCELLANEOUS

## **TYPE 2 PROCEDURES**

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.

D2951 Pin retention - per tooth, in addition to restoration.

D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

### **DESENSITIZATION: D9911**

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

**TYPE 3 PROCEDURES**  
**PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge**  
**For Additional Limitations - See Limitations**

**INLAY RESTORATIONS**

- D2510 Inlay - metallic - one surface.
- D2520 Inlay - metallic - two surfaces.
- D2530 Inlay - metallic - three or more surfaces.
- D2610 Inlay - porcelain/ceramic - one surface.
- D2620 Inlay - porcelain/ceramic - two surfaces.
- D2630 Inlay - porcelain/ceramic - three or more surfaces.
- D2650 Inlay - resin-based composite - one surface.
- D2651 Inlay - resin-based composite - two surfaces.
- D2652 Inlay - resin-based composite - three or more surfaces.

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.
- D2543 Onlay - metallic - three surfaces.
- D2544 Onlay - metallic - four or more surfaces.
- D2642 Onlay - porcelain/ceramic - two surfaces.
- D2643 Onlay - porcelain/ceramic - three surfaces.
- D2644 Onlay - porcelain/ceramic - four or more surfaces.
- D2662 Onlay - resin-based composite - two surfaces.
- D2663 Onlay - resin-based composite - three surfaces.
- D2664 Onlay - resin-based composite - four or more surfaces.

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, D2753, 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, D6753, D6780, D6781, D6782, D6783, D6784, 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, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

**CROWNS SINGLE RESTORATIONS**

- D2710 Crown - resin-based composite (indirect).
- D2712 Crown - 3/4 resin-based composite (indirect).
- D2720 Crown - resin with high noble metal.
- D2721 Crown - resin with predominantly base metal.
- D2722 Crown - resin with noble metal.
- D2740 Crown - porcelain/ceramic.
- D2750 Crown - porcelain fused to high noble metal.
- D2751 Crown - porcelain fused to predominantly base metal.
- D2752 Crown - porcelain fused to noble metal.
- D2753 Crown-porcelain fused to titanium and titanium alloys.
- D2780 Crown - 3/4 cast high noble metal.
- D2781 Crown - 3/4 cast predominantly base metal.
- D2782 Crown - 3/4 cast noble metal.
- D2783 Crown - 3/4 porcelain/ceramic.
- D2790 Crown - full cast high noble metal.
- D2791 Crown - full cast predominantly base metal.



## TYPE 3 PROCEDURES

D2792 Crown - full cast noble metal.

D2794 Crown - titanium and titanium alloys.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, 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, D6753, D6780, D6781, D6782, D6783, D6784, 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.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. Coverage is limited to necessary placement resulting from decay or traumatic injury.

### CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

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

### POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.

D2954 Prefabricated post and core in addition to crown.

### VENEERS

D2960 Labial veneer (resin laminate) - direct.

D2961 Labial veneer (resin laminate) - indirect.

D2962 Labial veneer (porcelain laminate) - indirect.

LABIAL VENEERS: D2960, D2961, D2962

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

Frequency is waived for accidental injury.

Benefits are considered on anterior teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

### FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair necessitated by restorative material failure.

D2981 Inlay repair necessitated by restorative material failure.

D2982 Onlay repair necessitated by restorative material failure.

D2983 Veneer repair necessitated by restorative material failure.

D6980 Fixed partial denture repair necessitated by restorative material failure.

D9120 Fixed partial denture sectioning.

### CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

### PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.

D5120 Complete denture - mandibular.

D5130 Immediate denture - maxillary.

D5140 Immediate denture - mandibular.

D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).

### TYPE 3 PROCEDURES

- D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
- D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
- D5225 Maxillary partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
- D5226 Mandibular partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
- D5227 Immediate maxillary partial denture-flexible base (including any clasps, rests and teeth).
- D5228 Immediate mandibular partial denture-flexible base (including any clasps, rests and teeth).
- D5282 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
- D5283 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
- D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth)-per quadrant.
- D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth)-per quadrant.
- D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
- D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
- D5810 Interim complete denture (maxillary).
- D5811 Interim complete denture (mandibular).
- D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
- D5821 Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular.
- D5863 Overdenture - complete maxillary.
- D5864 Overdenture - partial maxillary.
- D5865 Overdenture - complete mandibular.
- D5866 Overdenture - partial mandibular.
- D5876 Add metal substructure to acrylic full denture (per arch).
- D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
- D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
- D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
- D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
- D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
- D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
- D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
- D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
- D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
- D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D5876, D6110, D6111, D6114, D6115

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

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5227, D5228, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

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

D6010, D6040, D6050, also contribute(s) to this limitation.

## TYPE 3 PROCEDURES

Frequency is waived for accidental injury.

Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

### DENTURE ADJUSTMENTS

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

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

Each arch is limited to 1 of any of these procedures per 3 year(s).

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

### DENTURE REPAIR

- D5511 Repair broken complete denture base, mandibular.
- D5512 Repair broken complete denture base, maxillary.
- D5520 Replace missing or broken teeth - complete denture (each tooth).
- D5611 Repair resin partial denture base, mandibular.
- D5612 Repair resin partial denture base, maxillary.
- D5621 Repair cast partial framework, mandibular.
- D5622 Repair cast partial framework, maxillary.
- D5630 Repair or replace broken retentive/clasping materials per tooth.
- D5640 Replace broken teeth - per tooth.

### ADD TOOTH/CLASP TO EXISTING PARTIAL

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

### DENTURE REBASES

- D5710 Rebase complete maxillary denture.
- D5711 Rebase complete mandibular denture.
- D5720 Rebase maxillary partial denture.
- D5721 Rebase mandibular partial denture.
- D5725 Rebase hybrid prosthesis.

DENTURE REBASE: D5710, D5711, D5720, D5721, D5725, D5765

Each arch is limited to 1 of any of these procedures per 3 year(s).

D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, also contribute(s) to this limitation.

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

### DENTURE RELINES

- D5730 Reline complete maxillary denture (direct).
- D5731 Reline complete mandibular denture (direct).
- D5740 Reline maxillary partial denture (direct).
- D5741 Reline mandibular partial denture (direct).
- D5750 Reline complete maxillary denture (indirect).
- D5751 Reline complete mandibular denture (indirect).
- D5760 Reline maxillary partial denture (indirect).
- D5761 Reline mandibular partial denture (indirect).
- D5765 Soft liner for complete or partial removable denture-indirect.

DENTURE REBASE: D5710, D5711, D5720, D5721, D5725, D5765

Each arch is limited to 1 of any of these procedures per 3 year(s).

D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, also contribute(s) to this limitation.

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

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5765

Each arch is limited to 1 of any of these procedures per 3 year(s).

D5710, D5711, D5720, D5721, D5725, also contribute(s) to this limitation.

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

## TYPE 3 PROCEDURES

### TISSUE CONDITIONING

- D5850 Tissue conditioning, maxillary.
- D5851 Tissue conditioning, mandibular.

### IMPLANTS

- D6010 Surgical placement of implant body: endosteal implant.
- D6040 Surgical placement: eposteal implant.
- D6050 Surgical placement: transosteal implant.
- D6051 Interim implant abutment placement.
- D6055 Connecting bar-implant supported or abutment supported.
- D6056 Prefabricated abutment - includes placement.
- D6057 Custom abutment - includes placement.
- D6191 Semi-precision abutment-placement.
- D6192 Semi-precision attachment-placement.

IMPLANT: D6010, D6040, D6050

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

D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284, D5286, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Benefits for procedures D6051, D6055, D6056, D6057, D6191 and D6192 will be contingent upon the implant being covered. Replacement for procedures D6056, D6057, D6191 and D6192 are limited to 1 of any of these procedures in 5 years.

### IMPLANT SERVICES

- D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments.
- D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.
- D6089 Accessing and retorquing loose implant screw - per screw.
- D6090 Repair implant supported prosthesis, by report.
- D6091 Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment.
- D6095 Repair implant abutment, by report.
- D6096 Remove broken implant retaining screw.
- D6100 Surgical removal of implant body.
- D6105 Removal of implant body not requiring bone removal nor flap elevation.
- D6190 Radiographic/surgical implant index, by report.
- D6197 Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.
- D6198 Remove interim implant component.

IMPLANT SERVICES: D6080, D6081, D6089, D6090, D6091, D6095, D6096, D6100, D6105, D6190, D6197, D6198

Coverage for D6080 and D6081 is limited to 2 of any of these procedures in a 12 month period.

Coverage for D6089, D6090, D6091, D6095 and D6096 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

### PROSTHODONTICS - FIXED

- D6058 Abutment supported porcelain/ceramic crown.
- D6059 Abutment supported porcelain fused to metal crown (high noble metal).
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
- D6061 Abutment supported porcelain fused to metal crown (noble metal).
- D6062 Abutment supported cast metal crown (high noble metal).
- D6063 Abutment supported cast metal crown (predominantly base metal).
- D6064 Abutment supported cast metal crown (noble metal).
- D6065 Implant supported porcelain/ceramic crown.
- D6066 Implant supported crown - porcelain fused to high noble alloys.
- D6067 Implant supported crown - high noble alloys.
- D6068 Abutment supported retainer for porcelain/ceramic FPD.
- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).

### TYPE 3 PROCEDURES

- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
- D6072 Abutment supported retainer for cast metal FPD (high noble metal).
- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
- D6074 Abutment supported retainer for cast metal FPD (noble metal).
- D6075 Implant supported retainer for ceramic FPD.
- D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.
- D6077 Implant supported retainer for metal FPD - high noble alloy.
- D6082 Implant supported crown-porcelain fused to predominantly base alloys.
- D6083 Implant supported crown-porcelain fused to noble alloys.
- D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
- D6086 Implant supported crown-predominantly base alloys.
- D6087 Implant supported crown-noble alloys.
- D6088 Implant supported crown-titanium and titanium alloys.
- D6094 Abutment supported crown - titanium and titanium alloys.
- D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
- D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
- D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
- D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
- D6121 Implant supported retainer for metal FPD-predominantly base alloys.
- D6122 Implant supported retainer for metal FPD-noble alloys.
- D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
- D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
- D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
- D6205 Pontic - indirect resin based composite.
- D6210 Pontic - cast high noble metal.
- D6211 Pontic - cast predominantly base metal.
- D6212 Pontic - cast noble metal.
- D6214 Pontic - titanium and titanium alloys.
- D6240 Pontic - porcelain fused to high noble metal.
- D6241 Pontic - porcelain fused to predominantly base metal.
- D6242 Pontic - porcelain fused to noble metal.
- D6243 Pontic-porcelain fused to titanium and titanium alloys.
- D6245 Pontic - porcelain/ceramic.
- D6250 Pontic - resin with high noble metal.
- D6251 Pontic - resin with predominantly base metal.
- D6252 Pontic - resin with noble metal.
- D6545 Retainer - cast metal for resin bonded fixed prosthesis.
- D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
- D6549 Resin retainer - for resin bonded fixed prosthesis.
- D6600 Retainer inlay - porcelain/ceramic, two surfaces.
- D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
- D6602 Retainer inlay - cast high noble metal, two surfaces.
- D6603 Retainer inlay - cast high noble metal, three or more surfaces.
- D6604 Retainer inlay - cast predominantly base metal, two surfaces.
- D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
- D6606 Retainer inlay - cast noble metal, two surfaces.
- D6607 Retainer inlay - cast noble metal, three or more surfaces.
- D6608 Retainer onlay - porcelain/ceramic, two surfaces.
- D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
- D6610 Retainer onlay - cast high noble metal, two surfaces.
- D6611 Retainer onlay - cast high noble metal, three or more surfaces.
- D6612 Retainer onlay - cast predominantly base metal, two surfaces.
- D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
- D6614 Retainer onlay - cast noble metal, two surfaces.
- D6615 Retainer onlay - cast noble metal, three or more surfaces.
- D6624 Retainer inlay - titanium.
- D6634 Retainer onlay - titanium.
- D6710 Retainer crown - indirect resin based composite.
- D6720 Retainer crown - resin with high noble metal.
- D6721 Retainer crown - resin with predominantly base metal.

### TYPE 3 PROCEDURES

- D6722 Retainer crown - resin with noble metal.
- D6740 Retainer crown - porcelain/ceramic.
- D6750 Retainer crown - porcelain fused to high noble metal.
- D6751 Retainer crown - porcelain fused to predominantly base metal.
- D6752 Retainer crown - porcelain fused to noble metal.
- D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
- D6780 Retainer crown - 3/4 cast high noble metal.
- D6781 Retainer crown - 3/4 cast predominantly base metal.
- D6782 Retainer crown - 3/4 cast noble metal.
- D6783 Retainer crown - 3/4 porcelain/ceramic.
- D6784 Retainer crown 3/4-titanium and titanium alloys.
- D6790 Retainer crown - full cast high noble metal.
- D6791 Retainer crown - full cast predominantly base metal.
- D6792 Retainer crown - full cast noble metal.
- D6794 Retainer crown - titanium and titanium alloys.
- D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, 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, D2753, 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.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, 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, D6753, D6780, D6781, D6782, D6783, D6784, 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.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12.

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

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

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, 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, D6753, D6780, D6781, D6782, D6783, D6784, 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.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

## TYPE 3 PROCEDURES

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

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

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, 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.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195

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

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, 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.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

## BONE AUGMENTATION

D6104 Bone graft at time of implant placement.

D6106 Guided tissue regeneration - resorbable barrier, per implant.

D6107 Guided tissue regeneration - non-resorbable barrier, per implant.

D7939 Indexing for osteotomy using dynamic robotic assisted or dynamic navigation.

D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.

D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach.

D7952 Sinus augmentation via a vertical approach.

D7953 Bone replacement graft for ridge preservation - per site.

D7956 Guided tissue regeneration, edentulous area - resorbable barrier, per site.

D7957 Guided tissue regeneration, edentulous area - non-resorbable barrier, per site.

BONE AUGMENTATION: D6104, D6106, D6107, D7939, D7950, D7951, D7952, D7953, D7956, D7957

Each quadrant is limited to 1 of any of these procedures per 5 year(s).

Coverage of D6104, D6106, D6107, D7939, D7950, D7951, D7952, D7953, D7956 and D7957 is limited to the treatment and placement of endosteal implant D6010, D6040 eposteal implant or D6050 transosteal implant.

## MISCELLANEOUS

D2975 Coping.

## ORTHODONTIC EXPENSE BENEFITS

Orthodontic expense benefits will be determined according to the terms of the plan for orthodontic expenses incurred by a Member.

**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 Benefit 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 Covered 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 a Member 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 covered under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

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 Planholder (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 the 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 Planholder.

**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 bands, brackets, or appliances are placed. 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 a Member who pursues a Program, but not beyond the date the Program ends; or
- b. at the time the service is rendered for a Member who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Member'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 before the Member became covered under this section.
2. in the first 6 months that a person is covered if the person is a Late Entrant.
3. in any quarter of a Program if the Member was not covered under this section for the entire quarter.
4. if the Member's coverage under this section terminates.
5. for which the Member is entitled to benefits under any worker'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 Member is not legally required to pay or would not have been made had no coverage 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, missing, or stolen orthodontic appliances.

## COORDINATION OF BENEFITS

This section applies if a covered person has dental coverage under more than one Plan definition below. All benefits provided under this plan 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 plan.

1. “Plan” refers to the group plan 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, trustee 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 (Title XVIII 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 person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.
4. “Claim Determination Period” refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.
5. “Custodial Parent” refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

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

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.
2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:
  - a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.
  - b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:
    - i. the parents are married;
    - ii. the parents are not separated (whether or not they ever have been married); or
    - iii. a court decree awards joint custody without specifying that one party has the responsibility to provide dental coverage.

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

- c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:
  - i. the Plan of the Custodial Parent;
  - ii. the Plan of the spouse of the Custodial Parent;
  - iii. the Plan of the non-Custodial Parent; and then
  - iv. the Plan of the spouse of the non-Custodial Parent.

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

- d. The benefits of a Plan that cover a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.
- e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.
- f. The benefits of a Plan that has covered a person for a longer period will be determined first.

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

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

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

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

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

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

## GENERAL PROVISIONS

**NOTICE OF CLAIM.** Written notice of a claim must be given to us within 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 Planholder's name, Member's name, and plan 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 immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

**PAYMENT OF BENEFITS.** All benefits will be paid to the Member unless otherwise agreed upon through your authorization or Provider contracts.

**FACILITY OF PAYMENT.** If a Member or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Member, 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 Member 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 Member 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 Member 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 Planholder to obtain the Plan is a representation and not a warranty. No misrepresentation by the Planholder will be used to deny a claim or to deny the validity of the Plan unless:

1. The Plan would not have been issued if we had known the truth; and
2. We have given the Planholder a copy of a written instrument signed by the Planholder that contains the misrepresentation.

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

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

