

Sample not a certificate of insurance

FEE SCHEDULE

Ameritas Group Dental, a division of Ameritas Life Insurance Corp. (an Ameritas Acacia Company), offers quality group dental and eye care products nationwide, and delivers an unmatched combination of service, benefits and features. Founded in 1887, Ameritas is one of the leading dental carriers in the nation. Ameritas Life Insurance Corp.'s successful performance during the past 100 years has resulted in high ratings from those who determine and monitor the standard for our industry. Ameritas Life consistently earns high ratings from the industry's leading independent insurance analysts for its outstanding financial strength and stability.

A (Excellent) by the A.M. Best Company, for financial strength and operating performance. This is the third-highest rating of Best's 15 rankings.

AA- (Very Strong) by Standard & Poor's for insurer financial strength. This is the fourth-highest of S&P's 21 ratings.

Ward's 50 Benchmark Group for life/health insurance companies achieving outstanding financial results in safety, consistency and performance over the past five years.

A UNIFI Company with over \$25 Billion of assets.

DENTAL HEALTH EXPERTISE

As one of the nation's leading providers of affordable dental health products and services, Ameritas' Group Division helps thousands of groups and individuals achieve and maintain good dental health by offering a variety of programs.

Dental coverage for more than 2 million people.

Coverage sold through thousands of agents and brokers in all 50 states and the District of Columbia. In New York, dental insurance is provided by First Ameritas Life Insurance Corp. of New York.

Ameritas insures and administers coverage for more than 20,000 employer groups.

More than \$400 million of in-force dental premium.

A UNIFI Company with over \$25 Billion in assets

CUSTOMER SERVICE EXCELLENCE

At Ameritas, Strong on Service is more than just a slogan - it's the way we do business. Designing dental plans that work for our clients and supporting those plans with efficient, informed, accessible service is what we're all about.

A recent survey performed by a well-known independent national research firm reported that Ameritas outperforms its competition in terms of quality, value, claims processing and customer service.

Our state-of-the-art electronic dental claims system was specifically designed for processing dental claims, and can easily handle dental plans with customized benefits, deductibles, maximums and coinsurance levels.

Normal turn-around time for processing and paying claims is 5 - 10 days, far faster than the industry average.

Between 2 and 3 million claims are processed each year.

Dollar accuracy of processed claims exceeds 99.3%.

To learn more, please visit ameritasgroup.com

PRODUCT DESCRIPTIONS

There is no reason for poor dental health. With all the advances in dental care, regular checkups and proper dental maintenance, no one should suffer from tooth decay or dental disease. By participating in the Ameritas dental program, your employees have the opportunity to make regular checkups much easier and less costly.

Attracting and keeping good employees is essential for the success of any company and a good benefits package is an important part of that success. Dental insurance is the #1 preferred voluntary benefit by employers and employees. Employees have realized the importance of dental insurance in keeping employees on the job (improved health and fewer sick days) and in recruiting new employees. And employers have learned to appreciate dental as an extremely important benefit in helping them care for their families.

) to dictate future rates.

Ameritas Managed Care Products

Employers achieve a balance between cost efficiency and employee choice.

PPO providers agree to provide dental care at contracted fees.

Employees have the option to receive care from any dentist they choose, although out-of-pocket expenses are likely higher with dentists outside the PPO network.

Approximately 75000 PPO network providers are available to employees.

Patients can be assured that providers on our PPO network provide the highest quality of care. They have undergone a quality assurance evaluation and periodic onsite office visits.

A first in the industry... **Dental Rewards**

Rewards insureds who care for their teeth and use only a portion of their annual maximum benefit during a benefit period. With Dental Rewards, an insured employee or dependent can earn additional benefits toward his/her next year's annual maximum benefit.

Insureds qualify by each filing a dental claim during the benefit period and using less than the plan's annual maximum threshold amount.

Helps insureds build their annual maximum benefit amount toward future covered dental procedures in a future benefit period.

Excellent for new groups.

Great option at renewal for existing groups.

PRODUCT DESCRIPTIONS

FUSION: *THE ULTIMATE CHOICE*

Employers get dental *and* eye care benefits in *one* plan at an affordable price.

Plan maximums, deductibles and frequencies are combined for dental and eye care - plan administrators deal with one plan, not two.

Plan can be tailored to fit employer needs - traditional, voluntary, cost-containment, etc.

Plan members can visit any dentist and receive benefits -- cost-saving PPO is available where dental networks exist.

Members can visit any eye doctor. 4



**Explanation of FUSION
Combined Plan Higher Cost**

This proposal assumes the dental and eye care products have a combined maximum, deductible or exam frequency. Listed below are the combined amounts for each category. Please refer to the dental and eye care plan highlights page for the specific amounts for dental and eye care.

Maximums

The maximums listed with the (*) on the plan highlights page for dental and eye care are subject to the maximum amount listed here.

Combined Dental and Eye Care Maximum - Each Benefit Period \$1000

Deductibles

The deductibles listed with the (*) on the plan highlights page for dental and eye care are subject to the maximum deductible amount listed here.

Combined Dental And Eye Care Deductible Amount:

Each Benefit Period \$75

When combining dental and eye care benefits, participation must match. In no event can a person be covered for the eye care plan and not be covered in the dental plan or vice versa.



**Explanation of FUSION
Combined Plan Medium Cost**

This proposal assumes the dental and eye care products have a combined maximum, deductible or exam frequency. Listed below are the combined amounts for each category. Please refer to the dental and eye care plan highlights page for the specific amounts for dental and eye care.

Maximums

The maximums listed with the (*) on the plan highlights page for dental and eye care are subject to the maximum amount listed here.

Combined Dental and Eye Care Maximum - Each Benefit Period \$1000

Deductibles

The deductibles listed with the (*) on the plan highlights page for dental and eye care are subject to the maximum deductible amount listed here.

Combined Dental And Eye Care Deductible Amount:

Each Benefit Period \$75

When combining dental and eye care benefits, participation must match. In no event can a person be covered for the eye care plan and not be covered in the dental plan or vice versa.



**Explanation of FUSION
Combined Plan Lower Cost E 3**

This proposal assumes the dental and eye care products have a combined maximum, deductible or exam frequency. Listed below are the combined amounts for each category. Please refer to the dental and eye care plan highlights page for the specific amounts for dental and eye care.

Maximums

The maximums listed with the (*) on the plan highlights page for dental and eye care are subject to the maximum amount listed here.

Combined Dental and Eye Care Maximum - Each Benefit Period \$750

Deductibles

The deductibles listed with the (*) on the plan highlights page for dental and eye care are subject to the maximum deductible amount listed here.

Combined Dental And Eye Care Deductible Amount:

Each Benefit Period \$75

When combining dental and eye care benefits, participation must match. In no event can a person be covered for the eye care plan and not be covered in the dental plan or vice versa.



American Federal Employees Group
PROPOSED DENTAL PLAN HIGHLIGHTS PAGE

PLAN 1

Combined Plan Higher

Cost Coinsurance (Plan Pays)

- Type 1 Procedures..... Schedule
- Type 2 Procedures..... Schedule
- Type 3 Procedures..... Schedule

Deductible Amounts

Type 1 Procedures..... Waived Type

2 and Type 3 Procedures

Calendar Year-Per Person \$50*

Maximum

Type 1, Type 2 and Type 3 Procedures

- Calendar Year-Per Person \$ 1000*
- Carry Over Amount - Per Person - Each Benefit Period \$250
- Benefit Threshold - Per Person - Each Benefit Period..... \$500
- Maximum Carry Over Amount..... \$1000

Allowance Table as outlined on the Plan Definition Page(s).

Limitations, Exclusions and Elimination Periods as outlined on the Limitation



American Federal Employees Group
PLAN DEFINITION PAGE

PLAN 1

Combined Plan Higher Cost

ALLOWANCE TABLE

Type 1 Procedures	Schedule - \$50.00
Type 2 Procedures	Schedule - \$50.00
Type 3 Procedures	Schedule - \$50.00

An insured has the option of choosing a PPO provider or non-PPO dentist.

All insureds are subject to a 12-Month elimination period on Type 3 procedures.

The proposal includes a PPO Network. A PPO Provider is a dentist who has entered into an agreement to provide services to Insureds at a contracted fee. (Type 1, Type 2, Type 3)

If the schedule chosen is less than the contracted fee, the patient is responsible for the difference between the schedule amount and the contracted fee. (Type 1, Type 2, Type 3)

American Federal Employees Group

PLAN 1

PLAN DEFINITION PAGE

After the first Benefit Period following the effective date of this plan, the Maximum Amount Per Insured Person as shown above may be increased by the Carry Over Amount if:

- a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and
- b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

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

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

- a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or
- b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

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

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

months from the date the Carry Over Amount was established.



American Federal Employees Group

PLAN 1

DENTAL SAMPLE PROCEDURE CATEGORIES

Combined Plan Higher Cost

The following is a sample list of dental procedures payable under this plan. A complete list of the procedures can be obtained by contacting your Ameritas Life Insurance Corp. Sales Representative. Please read the "Limitations" section for additional coverage information. *Current Dental Terminology* © 2004 American Dental Association. All rights reserved.

PROC NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
Type 1		
D0120	Periodic Oral Evaluation (Twice in a Benefit Period).	\$ 20.00
D1110	Prophylaxis - adult (Twice in a Benefit Period).	50.00
D1203	Topical Fluoride (separate code) in conjunction with prophylaxis. (Coverage for fluoride treatment is limited to persons age 18 and under and to one treatment in a Benefit Period.)	19.00
Type 2		
D0210	Intraoral - complete series (including bitewings).	60.00
D0272	Bitewings - two films (Twice in a Benefit Period).	22.00
D2140	Amalgam restoration - one surface, primary or permanent.	53.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	60.00
D7240	Surgical removal of tooth (completely bony).	125.00
D9220	Deep sedation/general anesthesia.	175.00
Type 3		
D5211	Maxillary partial denture - resin base.	375.00
D5510	Denture repair - Repair broken base.	45.00
D3310	Endodontics - root canal, anterior.	200.00
D434 1	Periodontal scaling and root planing, four or more teeth. Each quadrant is eligible for consideration once in a 2 year period.	65.00
D2792	Crown - full cast noble metal.	280.00
D2980	Crown repair.	75.00
D6242	Pontics - porcelain fused to noble metal.	280.00



American Federal Employees Group
PROPOSED DENTAL PLAN HIGHLIGHTS PAGE

PLAN 2

Combined Plan Medium

Cost Coinsurance (Plan Pays)

Type 1 Procedures.....	Schedule
Type 2 Procedures.....	Schedule
Type 3 Procedures.....	Schedule

Deductible Amounts

Type 1 Procedures..... Waived Type

2 and Type 3 Procedures

Calendar Year-Per Person \$50*

Maximum

Type 1, Type 2 and Type 3 Procedures

Calendar Year-Per Person	\$ 1000*
Carry Over Amount - Per Person - Each Benefit Period	\$250
Benefit Threshold - Per Person - Each Benefit Period.....	\$500
Maximum Carry Over Amount.....	\$1000

Allowance Table as outlined on the Plan Definition Page(s).

Limitations, Exclusions and Elimination Periods as outlined on the limitations:



American Federal Employees Group
PLAN DEFINITION PAGE

PLAN 2

Combined Plan Medium Cost

ALLOWANCE TABLE

Type 1 Procedures	Schedule - \$40.00
Type 2 Procedures	Schedule - \$40.00
Type 3 Procedures	Schedule - \$40.00

An insured has the option of choosing a PPO provider or non-PPO

dentist. The rates are based on Standard Industry Code 922011.

All insureds are subject to a 12-Month elimination period on Type 3 procedures.

The proposal includes a PPO Network. A PPO Provider is a dentist who has entered into an agreement to provide services to Insureds at a contracted fee. (Type 1, Type 2, Type 3)

If the schedule chosen is less than the contracted fee, the patient is responsible for the difference between the schedule amount and the contracted fee. (Type 1, Type 2, Type 3)



PLAN DEFINITION PAGE

After the first Benefit Period following the effective date of this plan, the Maximum Amount Per Insured Person as shown above may be increased by the Carry Over Amount if:

- a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and
- b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

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

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

- a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or
- b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

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

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

months from the date the Carry Over Amount was established.

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PLAN 2

DENTAL SAMPLE PROCEDURE CATEGORIES

Combined Plan Medium Cost

The following is a sample list of dental procedures payable under this plan. A complete list of the procedures can be obtained by contacting your Ameritas Life Insurance Corp. Sales Representative. Please read the "Limitations" section for additional coverage information. *Current Dental Terminology* © 2004 American Dental Association. All rights reserved.

PROC NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
Type 1		
D0120	Periodic Oral Evaluation (Twice in a Benefit Period).	\$ 16.00
D1110	Prophylaxis - adult (Twice in a Benefit Period).	40.00
D1203	Topical Fluoride (separate code) in conjunction with prophylaxis. (Coverage for fluoride treatment is limited to persons age 18 and under and to one treatment in a Benefit Period.)	15.00
Type 2		
D0210	Intraoral - complete series (including bitewings).	48.00
D0272	Bitewings - two films (Twice in a Benefit Period).	18.00
D2140	Amalgam restoration - one surface, primary or permanent.	42.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	48.00
D7240	Surgical removal of tooth (completely bony).	100.00
D9220	Deep sedation/general anesthesia.	140.00
Type 3		
D5211	Maxillary partial denture - resin base.	300.00
D5510	Denture repair - Repair broken base.	36.00
D3310	Endodontics - root canal, anterior.	160.00
D434 1	Periodontal scaling and root planing, four or more teeth. Each quadrant is eligible for consideration once in a 2 year period.	52.00
D2792	Crown - full cast noble metal.	224.00
D2980	Crown repair.	60.00
D6242	Pontics - porcelain fused to noble metal.	224.00



American Federal Employees Group
PROPOSED DENTAL PLAN HIGHLIGHTS PAGE

PLAN 3

Combined Plan Lower

Cost Coinsurance (Plan Pays)

Type 1 Procedures.....	Schedule
Type 2 Procedures.....	Schedule
Type 3 Procedures.....	Schedule

Deductible Amounts

Type 1 Procedures..... Waived Type

2 and Type 3 Procedures

Calendar Year-Per Person \$50*

Maximum

Type 1, Type 2 and Type 3 Procedures

Calendar Year-Per Person	\$750*
Carry Over Amount - Per Person - Each Benefit Period	\$125
Benefit Threshold - Per Person - Each Benefit Period.....	\$250
Maximum Carry Over Amount.....	\$500

Allowance Table as outlined on the Plan Definition Page(s).

Limitations, Exclusions and Elimination Periods as outlined on the Limitation benefits coordinator.



American Federal Employees Group
PLAN DEFINITION PAGE

PLAN 3

Combined Plan Lower Cost

ALLOWANCE TABLE

Type 1 Procedures	Schedule - \$30.00
Type 2 Procedures	Schedule - \$30.00
Type 3 Procedures	Schedule \$30.00

An insured has the option of choosing a PPO provider or non-PPO

dentist. The rates are based on Standard Industry Code 922011.

All insureds are subject to a 12-Month elimination period on Type 3 procedures.

The proposal includes a PPO Network. A PPO Provider is a dentist who has entered into an agreement to provide services to Insureds at a contracted fee. (Type 1, Type 2, Type 3)

If the schedule chosen is less than the contracted fee, the patient is responsible for the difference between the schedule amount and the contracted fee. (Type 1, Type 2, Type 3)



PLAN DEFINITION PAGE

After the first Benefit Period following the effective date of this plan, the Maximum Amount Per Insured Person as shown above may be increased by the Carry Over Amount if:

- a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and
- b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

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

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

- a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or
- b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

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

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

months from the date the Carry Over Amount was established.



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DENTAL SAMPLE PROCEDURE CATEGORIES

PLAN 3

Combined Plan Lower Cost

The following is a sample list of dental procedures payable under this plan. A complete list of the procedures can be obtained by contacting your Ameritas Life Insurance Corp. Sales Representative. Please read the "Limitations" section for additional coverage information. *Current Dental Terminology* © 2004 American Dental Association. All rights reserved.

PROC NO.	DESCRIPTION OF SERVICE	MAXIMUM COVERED EXPENSE
Type 1		
D0120	Periodic Oral Evaluation (Twice in a Benefit Period).	\$ 12.00
D1110	Prophylaxis - adult (Twice in a Benefit Period).	30.00
D1203	Topical Fluoride (separate code) in conjunction with prophylaxis. (Coverage for fluoride treatment is limited to persons age 18 and under and to one treatment in a Benefit Period.)	11.00
Type 2		
D0210	Intraoral - complete series (including bitewings).	36.00
D0272	Bitewings - two films (Twice in a Benefit Period).	13.00
D2140	Amalgam restoration - one surface, primary or permanent.	32.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	36.00
D7240	Surgical removal of tooth (completely bony).	75.00
D9220	Deep sedation/general anesthesia.	105.00
Type 3		
D5211	Maxillary partial denture - resin base.	225.00
D5510	Denture repair - Repair broken base.	27.00
D3310	Endodontics - root canal, anterior.	120.00
D434 1	Periodontal scaling and root planing, four or more teeth. Each quadrant is eligible for consideration once in a 2 year period.	39.00
D2792	Crown - full cast noble metal.	168.00
D2980	Crown repair.	45.00
D6242	Pontics - porcelain fused to noble metal.	168.00

DENTAL LIMITATIONS PAGE

LIMITATIONS. Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. for any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the second bicuspid are considered cosmetic.
2. to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within five years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the insured person is covered under the dental expense benefit.
3. for initial placement of any prosthetic appliance of fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under the dental expense benefit. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such appliance or fixed partial denture must include the replacement of the extracted tooth or teeth.
4. for any procedure begun before the insured person was covered under the dental expense benefit.
5. for any procedure begun after the insured's insurance under the dental expense benefit terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the insured's insurance under the dental expense benefit terminates.
6. to replace lost or stolen appliances.
7. for appliances, restorations, or procedures to:
 - a. alter vertical dimension;
 - b. restore or maintain occlusion;
 - c. splint or replace tooth structure lost because of abrasion or attrition
10. for any procedure which is not shown on the Table of Dental Procedures.
11. for orthodontic treatment. (Unless otherwise specified in this contract.)

American Federal Employees Group Association

DENTAL LIMITATIONS PAGE

LIMITATIONS. Covered Expenses will not include and no benefits will be payable for expenses incurred for:

12. for which the insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
13. for charges for which the insured person is not liable or which would not have been made had no insurance been in force.
14. for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.
15. because of war or any act of war, declared or not.

Eye Care Insurance...Take a Close Look at Quality Eye Care



Vision Perfect is an eye care product offered across the nation to businesses, large and small, by Ameritas Life Insurance Corp.. With Vision Perfect, insureds select the eye doctor of their choice, pay the doctor for all services, and then submit a claim to Ameritas Life Insurance Corp. for reimbursement. Benefits are reimbursed according to the schedule chosen by the employer, or the employer can choose a flat annual maximum. The plan is easy to administer and includes money-saving offers through an eye care network affiliate. Vision Perfect is available as a stand-alone plan, with an affordable Ameritas Life Insurance Corp. dental plan, as part of a combined dental and eye care plan, or with another group dental or medical plan.

To learn more, please visit ameritasgroup.com



American Federal Employees Group
 PROPOSED EYE CARE PLAN HIGHLIGHTS

Plan 1
 Vision Perfect

Combined Plan Higher Cost

Deductible - Calendar Year Deductible:
 Exams, Lenses (other than contact lenses) or Frames/Contact lenses \$ 25.00*

Maximum - Exams and Materials - Per Benefit Period None

SERVICE

Examination

MAXIMUM COVERED EXPENSE 45.00

Includes case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refracture status; binocular balance; tonometry test for glaucoma; gross visual field when indicated; summary finding; prescribing of lenses.

Frames 80.00

Lenses (Per pair of lens - Patient pays remainder)

Single 40.00

Bifocal 60.00

Trifocal 75.00

No line bifocal or progressive power 80.00

Lenticular 80.00

Contact Lenses 120.00

Frequency Allowance

Exam 12 Months

Lens 12 Months OK CONTACT LENSES ANNUAL

Frames 24 Months

The patient will be responsible for any deductible, if applicable, and any cost over the specified plan benefits, as stated above.

Limitations, Exclusions and Elimination Periods As outlined on the Limitation Page(s).

Eye Care Insurance...Take a Close Look at Quality Eye Care





American Federal Employees Group
 PROPOSED EYE CARE PLAN HIGHLIGHTS

Plan 2
 Vision Perfect

Combined Plan Medium Cost

Deductible - Calendar Year Deductible:
 Exams, Lenses (other than contact lenses) or Frames/Contact lenses \$ 25.00*

Maximum - Exams and Materials - Per Benefit Period None

SERVICE

MAXIMUM COVERED EXPENSE 45.00

Examination

Includes case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refracture status; binocular balance; tonometry test for glaucoma; gross visual field when indicated; summary finding; prescribing of lenses.

Frames 80.00

Lenses (Per pair of lens - Patient pays remainder)

Single 40.00

Bifocal 60.00

Trifocal 75.00

No line bifocal or progressive power 80.00

Lenticular 80.00

Contact Lenses 120.00

Frequency Allowance

Exam 12 Months

Lens 12 Months

Frames 24 Months

The patient will be responsible for any deductible, if applicable, and any cost over the specified plan benefits, as stated above.

Limitations, Exclusions and Elimination Periods As outlined on the Limitation Page(s).



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Plan 2 Vision
Perfect



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 PROPOSED EYE CARE PLAN HIGHLIGHTS

Plan 3
 Vision Perfect

Combined Plan Lower Cost

Deductible - Calendar Year Deductible:
 Exams, Lenses (other than contact lenses) or Frames/Contact lenses \$ 25.00*

Maximum - Exams and Materials - Per Benefit Period None

SERVICE

MAXIMUM
COVERED
EXPENSE 45.00

Examination

Includes case history; external examination of the eye and adnexa;
 ophthalmoscopic examination; determination of refracture status; binocular
 balance; tonometry test for glaucoma; gross visual field when indicated;
 summary finding; prescribing of lenses.

Frames 80.00

Lenses (Per pair of lens - Patient pays remainder)

Single 40.00

Bifocal 60.00

Trifocal 75.00

No line bifocal or progressive power 80.00

Lenticular 80.00

Contact Lenses 120.00

Frequency Allowance

Exam 12 Months

Lens 12 Months

Frames 24 Months

The patient will be responsible for any deductible, if applicable, and any cost over the specified plan benefits, as stated above.

Limitations, Exclusions and Elimination Periods As outlined on the Limitation Page(s).



American Federal Employees Group

Plan 3 Vision
Perfect



American Federal Employees Group

EYE CARE LIMITATIONS PAGE

VISION PERFECT

LIMITATIONS. Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. vision examinations more than the frequency as indicated on the plan definition page.
2. lenses more than the frequency as indicated on the plan definition page.
3. frames more than the frequency as indicated on the plan definition page.
4. contact lenses more than once in any twelve month period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the twelve month period. When lenses and frames are chosen, expenses for contact lenses are not Covered Expenses during the twelve month period.
5. examinations performed or frames or lenses ordered before the Insured was covered under the eye care expense benefits.
6. subject to extension of benefits, any examination performed or frame or lens ordered after the insured's coverage under the eye care expense benefits ceases.
7. sub-normal eye care aids; orthoptic or eye care training or any associated testing.
8. non-prescription lenses.
9. replacement or repair of lost or broken lenses or frames except at normal intervals.
10. any eye examination or corrective eyewear required by an employer as a condition of employment.
11. medical or surgical treatment of the eyes.
12. any service or supply not shown on the Schedule of Eye Care Procedures.
13. coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.
14. lenses and frames during the first twelve months that a person is insured under the eye care expense benefits, when the person is a Late Entrant, as defined.

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 is based upon the Current Dental Terminology, (CDT-5), copyrighted 2004, American Dental Association. **No benefits are payable for a procedure that is not listed.**

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

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

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.

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

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

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

TYPE 1 PROCEDURES
Plan 1
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense \$20.00 \$20.00 \$20.00
ROUTINE ORAL EVALUATION	
D0120 Periodic oral evaluation.	
D0150 Comprehensive oral evaluation - new or established patient.	
D0180 Comprehensive periodontal evaluation - new or established patient.	
COMPREHENSIVE EVALUATION: D0150, D0180	
<ul style="list-style-type: none"> • Coverage is limited to 1 of each of these procedures per 1 provider. • In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period. • D0120 also contribute(s) to this limitation. • If frequency met, will be considered at an alternate benefit of a D0120 and count toward this frequency. 	
ROUTINE EVALUATION: D0120	
<ul style="list-style-type: none"> • Coverage is limited to 2 of any of these procedures per 1 benefit period. • D0150, D0180 also contribute(s) to this limitation. • Coverage is subject to Combined Dental and Eye Care Exam Frequencies. 	
 PROPHYLAXIS (CLEANING) AND FLUORIDE	
D1110 Prophylaxis - adult.	\$50.00
D1120 Prophylaxis - child.	\$34.00
D1201 Topical application of fluoride (including prophylaxis) - child.	\$53.00
D1203 Topical application of fluoride (prophylaxis not included) - child.	\$19.00
D1204 Topical application of fluoride (prophylaxis not included) - adult.	\$19.00
D1205 Topical application of fluoride (including prophylaxis) - adult.	\$69.00
FLUORIDE: D1201, D1203, D1204, D1205	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 1 benefit period. • Benefits are considered for persons age 18 and under. • In addition, D1201, D1205 coverage is limited to 2 of any of these procedures per 1 benefit period. • D1110, D4355, D4910 also contribute(s) to this limitation. • The frequency limitation will not be exceeded for either Fluoride or Prophylaxis (cleaning). 	
PROPHYLAXIS: D1110, D1120	
<ul style="list-style-type: none"> • Coverage is limited to 2 of any of these procedures per 1 benefit period. • D1201, D1205, D4355, D4910 also contribute(s) to this limitation. • An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures. 	
 FULL MOUTH DEBRIDEMENT	
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.	\$50.00
FULL MOUTH DEBRIDEMENT: D4355	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 5 year(s). • D1110, D1120, D1201, D1205, D4910 also contribute(s) to this limitation. 	
 PERIODONTAL MAINTENANCE	
D4910 Periodontal maintenance.	\$50.00
PERIODONTAL MAINTENANCE: D4910	
<ul style="list-style-type: none"> • Coverage is limited to 2 of any of these procedures per 1 benefit period. • D1110, D1120, D1201, D1205, D4355 also contribute(s) to this limitation. • Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure. 	

TYPE 2 PROCEDURES
 Plan 1
 BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
LIMITED ORAL EVALUATION	
D0140 Limited oral evaluation - problem focused.	\$20.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$20.00
LIMITED ORAL EVALUATION: D0140, D0170	
<ul style="list-style-type: none"> • Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120 and count towards this frequency. 	
COMPLETE SERIES OR PANORAMIC FILM	
D0210 Intraoral - complete series (including bitewings).	\$60.00
D0330 Panoramic film.	\$60.00
COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 3 year(s). 	
OTHER XRAYS	
D0220 Intraoral - periapical first film.	\$12.00
D0230 Intraoral - periapical each additional film.	\$12.00
D0240 Intraoral - occlusal film.	\$12.00
D0250 Extraoral - first film.	\$14.00
D0260 Extraoral - each additional film.	\$14.00
PERIAPICAL FILMS: D0220, D0230	
<ul style="list-style-type: none"> • The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210. 	
BITE WING FILMS	
D0270 Bitewing - single film.	\$12.00
D0272 Bitewings - two films.	\$22.00
D0274 Bitewings - four films.	\$22.00
D0277 Vertical bitewings - 7 to 8 films.	\$33.00
BITE WING FILMS: D0270, D0272, D0274	
<ul style="list-style-type: none"> • Coverage is limited to 2 of any of these procedures per 1 benefit period. • D0277 also contribute(s) to this limitation. • The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210. 	
VERTICAL BITE WING FILM: D0277	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 3 year(s). • The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210. 	
ORAL PATHOLOGY/LABORATORY	
D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$10.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$20.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$20.00
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). • Coverage is limited to 1 examination per biopsy/excision. 	
AMALGAM RESTORATIONS (FILLINGS)	
D2140 Amalgam - one surface, primary or permanent.	\$53.00
D2150 Amalgam - two surfaces, primary or permanent.	\$68.00
D2160 Amalgam - three surfaces, primary or permanent.	\$68.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$68.00
AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 6 month(s). • D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911 also contribute(s) to this limitation. 	
RESIN RESTORATIONS (FILLINGS)	
D2330 Resin-based composite - one surface, anterior.	\$53.00

TYPE 2 PROCEDURES

Maximum Covered
Expense

D2331 Resin-based composite - two surfaces, anterior.	\$68.00
D2332 Resin-based composite - three surfaces, anterior.	\$68.00
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).	\$68.00
D2391 Resin-based composite - one surface, posterior.	\$58.00
D2392 Resin-based composite - two surfaces, posterior.	\$75.00
D2393 Resin-based composite - three surfaces, posterior.	\$75.00
D2394 Resin-based composite - four or more surfaces, posterior.	\$82.00
D2410 Gold foil - one surface.	\$53.00
D2420 Gold foil - two surfaces.	\$68.00
D2430 Gold foil - three surfaces.	\$68.00

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

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

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.	\$68.00
D2930 Prefabricated stainless steel crown - primary tooth.	\$68.00
D293 1 Prefabricated stainless steel crown - permanent tooth.	\$68.00
D2932 Prefabricated resin crown.	\$68.00
D2933 Prefabricated stainless steel crown with resin window.	\$68.00
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.	\$68.00

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).	\$68.00
D2712 Crown - 3/4 resin-based composite (indirect).	\$252.00
D2720 Crown - resin with high noble metal.	\$68.00
D2721 Crown - resin with predominantly base metal.	\$68.00
D2722 Crown - resin with noble metal.	\$68.00

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2390, D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2930, D2931, D2932, D2933, D2934, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

SEDATIVE FILLING D2940

Sedative filling.	\$45.00
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NON-SURGICAL EXTRACTIONS

D7 111 Extraction, coronal remnants - deciduous tooth.	\$60.00 \$60.00
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	

SURGICAL EXTRACTIONS

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	\$125.00
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TYPE 2 PROCEDURES

Maximum Covered

	Expense
D7220 Removal of impacted tooth - soft tissue.	\$125.00
D7230 Removal of impacted tooth - partially bony.	\$125.00
D7240 Removal of impacted tooth - completely bony.	\$125.00
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.	\$157.00
D7250 Surgical removal of residual tooth roots (cutting procedure).	\$125.00

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.	\$125.00
D7261 Primary closure of a sinus perforation.	\$125.00
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$125.00
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$125.00
D7280 Surgical access of an unerupted tooth.	\$125.00
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.	\$125.00
D7283 Placement of device to facilitate eruption of impacted tooth.	\$38.00
D7310 Alveoloplasty in conjunction with extractions - per quadrant.	\$100.00
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$50.00
D7320 Alveoloplasty not in conjunction with extractions - per quadrant. D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$100.00 \$50.00
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).	\$125.00 \$125.00
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$125.00
D7410 Excision of benign lesion up to 1.25 cm.	\$125.00
D7411 Excision of benign lesion greater than 1.25 cm.	\$138.00
D7412 Excision of benign lesion, complicated.	\$125.00
D7413 Excision of malignant lesion up to 1.25 cm.	\$125.00
D7414 Excision of malignant lesion greater than 1.25 cm.	\$138.00
D7415 Excision of malignant lesion, complicated.	\$125.00
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm. D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.	\$125.00 \$125.00
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.	\$125.00 \$125.00
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$125.00
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$100.00
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.	\$83.00 \$83.00
D7473 Removal of torus mandibularis.	\$83.00
D7485 Surgical reduction of osseous tuberosity.	\$42.00
D7490 Radical resection of maxilla or mandible.	\$125.00
D7510 Incision and drainage of abscess - intraoral soft tissue. D7520 Incision and drainage of abscess - extraoral soft tissue.	\$75.00 \$125.00
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$100.00
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.	\$125.00 \$125.00 \$125.00
D7911 Complicated suture - up to 5 cm.	\$50.00
D7912 Complicated suture - greater than 5 cm.	\$50.00
D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure.	\$125.00
D7963 Frenuloplasty.	\$157.00
D7970 Excision of hyperplastic tissue - per arch.	\$100.00
D7972 Surgical reduction of fibrous tuberosity.	\$38.00
D7980 Sialolithotomy.	\$125.00
D7983 Closure of salivary fistula.	\$125.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

TYPE 2 PROCEDURES

	Maximum Covered Expense
BIOPSY OF ORAL TISSUE	
D7285 Biopsy of oral tissue - hard (bone, tooth).	\$100.00
D7286 Biopsy of oral tissue - soft.	\$100.00
D7287 Exfoliative cytological sample collection.	\$50.00
D7288 Brush biopsy - transepithelial sample collection.	\$50.00
PALLIATIVE	
D91 10 Palliative (emergency) treatment of dental pain - minor procedure.	\$48.00
PALLIATIVE TREATMENT: D9110	
<ul style="list-style-type: none"> • Not covered in conjunction with other procedures, except diagnostic x-ray films. 	
ANESTHESIA-GENERAL/IV	
D9220 Deep sedation/general anesthesia - first 30 minutes.	\$175.00
D9221 Deep sedation/general anesthesia - each additional 15 minutes.	\$57.00
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.	\$116.00
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.	\$28.00
GENERAL ANESTHESIA: D9220, D9221, D9241, D9242	
<ul style="list-style-type: none"> • Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered. 	
PROFESSIONAL CONSULT/VISIT/SERVICES	
D93 10 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).	\$28.00
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.	\$20.00
D9440 Office visit - after regularly scheduled hours.	\$55.00
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.	\$35.00
CONSULTATION: D9310	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 1 provider. 	
OFFICE VISIT: D9430, D9440	
<ul style="list-style-type: none"> • Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater. 	
MELANO	
US	
D295 1 Pin retention - per tooth, in addition to restoration.	\$25.00
D991 1 Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$53.00
DESENSITIZATION: D991 1	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 6 month(s). • D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394 also contribute(s) to this limitation. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations. 	

TYPE 3 PROCEDURES

Plan 1

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

	Maximum Covered
INLAY RESTORATIONS	Expense
D2510 Inlay - metallic - one surface.	\$190.00
D2520 Inlay - metallic - two surfaces.	\$235.00
D2530 Inlay - metallic - three or more surfaces.	\$235.00
D2610 Inlay - porcelain/ceramic - one surface.	\$190.00
D2620 Inlay - porcelain/ceramic - two surfaces.	\$235.00
D2630 Inlay - porcelain/ceramic - three or more surfaces.	\$235.00
D2650 Inlay - resin-based composite - one surface.	\$190.00
D2651 Inlay - resin-based composite - two surfaces.	\$235.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$235.00
INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652	
<ul style="list-style-type: none"> • 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.	\$340.00
D2543 Onlay - metallic - three surfaces.	\$340.00
D2544 Onlay - metallic - four or more surfaces.	\$340.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$340.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$340.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$340.00
D2662 Onlay - resin-based composite - two surfaces. D2663	\$335.00
Onlay - resin-based composite - three surfaces.	\$335.00
D2664 Onlay - resin-based composite - four or more surfaces.	\$335.00
ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D2390, D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2933, D2934, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury. 	
CROWNS SINGLE RESTORATIONS	
D2740 Crown - porcelain/ceramic substrate.	\$280.00
D2750 Crown - porcelain fused to high noble metal.	\$280.00
D2751 Crown - porcelain fused to predominantly base metal.	\$280.00
D2752 Crown - porcelain fused to noble metal.	\$280.00
D2780 Crown - 3/4 cast high noble metal.	\$280.00
D2781 Crown - 3/4 cast predominantly base metal.	\$280.00
D2782 Crown - 3/4 cast noble metal.	\$280.00
D2783 Crown - 3/4 porcelain/ceramic.	\$280.00
D2790 Crown - full cast high noble metal.	\$280.00
D2791 Crown - full cast predominantly base metal.	\$280.00
D2792 Crown - full cast noble metal.	\$280.00
D2794 Crown - titanium.	\$280.00
RECEMENT	
D2910 Recement inlay, onlay, or partial coverage restoration.	\$25.00
D2915 Recement cast or prefabricated post and core. D2920	\$13.00
Recement crown.	\$25.00
D6930 Recement fixed partial denture.	\$35.00

TYPE 3 PROCEDURES

Maximum Covered Expense

CORE BUILD-UP

D2950	Core buildup, including any pins.	\$70.00
D6973	Core build up for retainer, including any pins.	\$70.00

POST AND CORE

D2952	Cast post and core in addition to crown.	\$105.00
D2954	Prefabricated post and core in addition to crown.	\$90.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	\$75.00
D6980	Fixed partial denture repair, by report.	\$85.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$48.00
D3221	Pulpal debridement, primary and permanent teeth.	\$48.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$200.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$200.00
D3333	Internal root repair of perforation defects.	\$75.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$75.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	\$63.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	\$63.00
D3430	Retrograde filling - per root.	\$70.00
D3450	Root amputation - per root.	\$110.00
D3920	Hemisection (including any root removal), not including root canal therapy.	\$110.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240

- Procedure D3220 is limited to primary teeth.

ENDODONTIC

C THERAPY (ROOT CANALS)

D3310	Anterior (excluding final restoration).	\$200.00
D3320	Bicuspid (excluding final restoration).	\$225.00
D3330	Molar (excluding final restoration).	\$300.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$113.00
D3346	Retreatment of previous root canal therapy - anterior.	\$200.00
D3347	Retreatment of previous root canal therapy - bicuspid.	\$225.00
D3348	Retreatment of previous root canal therapy - molar.	\$300.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330 also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	\$225.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	\$225.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	\$225.00
D3426	Apicoectomy/periradicular surgery (each additional root).	\$75.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$150.00
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TYPE 3 PROCEDURES

Maximum Covered
Expense

D421 1	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$75.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$175.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$88.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$375.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$188.00
D4263	Bone replacement graft - first site in quadrant.	\$130.00
D4264	Bone replacement graft - each additional site in quadrant.	\$155.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	\$65.00
D4270	Pedicle soft tissue graft procedure.	\$225.00
D4271	Free soft tissue graft procedure (including donor site surgery).	\$250.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	\$250.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	\$38.00
D4275	Soft tissue allograft.	\$250.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	\$250.00

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

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

CROWN LENGTHENING

D4249	Clinical crown lengthening - hard tissue.	\$140.00
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NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	\$65.
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crevicular tissue, per tooth, by report.

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).
- A scaling and root planing or periodontal maintenance procedure must be performed in this quadrant within 2 years prior to the date of service for this procedure.

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5 110	Complete denture - maxillary.	\$375.00
D5120	Complete denture - mandibular.	\$375.00
D5130	Immediate denture - maxillary.	\$375.00
D5140	Immediate denture - mandibular.	\$375.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	\$375.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	\$375.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$375.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$375.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	\$375.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	\$375.00

TYPE 3 PROCEDURES

Maximum Covered
Expense

D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	\$250.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	\$375.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	\$375.00
D5810	Interim complete denture (maxillary).	\$175.00
D5811	Interim complete denture (mandibular).	\$175.00
D5820	Interim partial denture (maxillary).	\$140.00
D5821	Interim partial denture (mandibular).	\$140.00
D5860	Overdenture - complete, by report.	\$375.00
D5861	Overdenture - partial, by report.	\$375.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	\$375.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	\$375.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	\$375.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	\$375.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	\$25.00
D5411	Adjust complete denture - mandibular.	\$25.00
D5421	Adjust partial denture - maxillary. D5422	\$25.00
	Adjust partial denture - mandibular.	\$25.00
DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422		
<ul style="list-style-type: none"> • Coverage is limited to dates of service more than 6 months after placement date. 		

DENTURE REPAIR

D5510	Repair broken complete denture base.	\$45.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	\$43.00
D5610	Repair resin denture base.	\$45.00
D5620	Repair cast framework.	\$45.00
D5630	Repair or replace broken clasp.	\$45.00
D5640	Replace broken teeth - per tooth.	\$43.00

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	\$45.00 \$50.00
D5660	Add clasp to existing partial denture.	

DENTURE REBASES

D5710	Rebase complete maxillary denture. D5711	\$120.00
D5720	Rebase complete mandibular denture. D5720	\$120.00
D5721	Rebase maxillary partial denture. D5721	\$120.00
	Rebase mandibular partial denture.	\$120.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside). D5731	\$60.00
D5740	Reline complete mandibular denture (chairside). D5740	\$60.00
D5741	Reline maxillary partial denture (chairside). D5741	\$60.00
D5750	Reline mandibular partial denture (chairside). D5750	\$110.00
D5751	Reline complete maxillary denture (laboratory). D5751	\$110.00
D5760	Reline complete mandibular denture (laboratory). D5760	\$110.00
D5761	Reline maxillary partial denture (laboratory). D5761	\$110.00
	Reline mandibular partial denture (laboratory).	\$110.00

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

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

TYPE 3 PROCEDURES

	Maximum Covered Expense
TISSUE CONDITIONING	
D5850 Tissue conditioning, maxillary.	\$33.00
D5851 Tissue conditioning, mandibular.	\$33.00
PROSTHODONTICS - FIXED	
D6058 Abutment supported porcelain/ceramic crown.	\$280.00
D6059 Abutment supported porcelain fused to metal crown (high noble metal).	\$280.00
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).	\$280.00
D6061 Abutment supported porcelain fused to metal crown (noble metal).	\$280.00
D6062 Abutment supported cast metal crown (high noble metal).	\$280.00
D6063 Abutment supported cast metal crown (predominantly base metal).	\$280.00
D6064 Abutment supported cast metal crown (noble metal).	\$280.00
D6065 Implant supported porcelain/ceramic crown.	\$280.00
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	\$280.00
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).	\$280.00
D6068 Abutment supported retainer for porcelain/ceramic FPD.	\$280.00
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	\$280.00
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	\$280.00
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).	\$280.00
D6072 Abutment supported retainer for cast metal FPD (high noble metal).	\$280.00
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).	\$280.00
D6074 Abutment supported retainer for cast metal FPD (noble metal).	\$280.00
D6075 Implant supported retainer for ceramic FPD.	\$280.00
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	\$280.00
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	\$280.00
D6094 Abutment supported crown - (titanium).	\$280.00
D6194 Abutment supported retainer crown for FPD - (titanium).	\$280.00
D6205 Pontic - indirect resin based composite.	\$252.00
D6210 Pontic - cast high noble metal.	\$280.00
D621 1 Pontic - cast predominantly base metal.	\$280.00
D6212 Pontic - cast noble metal.	\$280.00
D6214 Pontic - titanium.	\$280.00
D6240 Pontic - porcelain fused to high noble metal.	\$280.00
D6241 Pontic - porcelain fused to predominantly base metal.	\$280.00
D6242 Pontic - porcelain fused to noble metal.	\$280.00
D6245 Pontic - porcelain/ceramic.	\$280.00
D6250 Pontic - resin with high noble metal.	\$280.00
D6251 Pontic - resin with predominantly base metal.	\$280.00
D6252 Pontic - resin with noble metal.	\$280.00
D6545 Retainer - cast metal for resin bonded fixed prosthesis.	\$140.00
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	\$140.00
D6600 Inlay - porcelain/ceramic, two surfaces.	\$235.00
D6601 Inlay - porcelain/ceramic, three or more surfaces.	\$259.00
D6602 Inlay - cast high noble metal, two surfaces.	\$259.00
D6603 Inlay - cast high noble metal, three or more surfaces.	\$285.00
D6604 Inlay - cast predominantly base metal, two surfaces.	\$224.00
D6605 Inlay - cast predominantly base metal, three or more surfaces.	\$246.00
D6606 Inlay - cast noble metal, two surfaces.	\$235.00
D6607 Inlay - cast noble metal, three or more surfaces.	\$259.00
D6608 Onlay - porcelain/ceramic, two surfaces.	\$340.00
D6609 Onlay - porcelain/ceramic, three or more surfaces.	\$374.00
D6610 Onlay - cast high noble metal, two surfaces.	\$285.00
D661 1 Onlay - cast high noble metal, three or more surfaces.	\$313.00
D6612 Onlay - cast predominantly base metal, two surfaces.	\$246.00
D6613 Onlay - cast predominantly base metal, three or more surfaces.	\$271.00
D6614 Onlay - cast noble metal, two surfaces.	\$259.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D6615 Onlay - cast noble metal, three or more surfaces. D6624 Inlay - titanium.	\$285.00
D6634 Onlay - titanium.	\$285.00
D6710 Crown - indirect resin based composite. D6720 Crown - resin with high noble metal.	\$313.00
D6721 Crown - resin with predominantly base metal. D6722 Crown - resin with noble metal. D6740 Crown - porcelain/ceramic.	\$252.00
D6750 Crown - porcelain fused to high noble metal.	\$280.00
D6751 Crown - porcelain fused to predominantly base metal.	\$280.00
D6752 Crown - porcelain fused to noble metal. D6780 Crown - 3/4 cast high noble metal. D6781 Crown - 3/4 cast predominantly base metal. D6782 Crown - 3/4 cast noble metal.	\$280.00
D6783 Crown - 3/4 porcelain/ceramic.	\$280.00
D6790 Crown - full cast high noble metal.	\$280.00
D6791 Crown - full cast predominantly base metal. D6792 Crown - full cast noble metal.	\$280.00
D6794 Crown - titanium.	\$280.00
D6940 Stress breaker.	\$280.00
FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794	\$280.00 \$75.00
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s) D2390, D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2933, D2934, 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. 	
FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D2390, D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2933, D2934, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194 also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252 also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252 also contribute(s) to this limitation. 	

TYPE 3 PROCEDURES

Maximum Covered
Expense

- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970 Cast post and core in addition to fixed partial denture retainer.	
D697 1 Cast post as part of fixed partial denture retainer.	\$100.00
D6972 Prefabricated post and core in addition to fixed partial denture retainer.	\$88.00
	\$88.00

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.	
D9952 Occlusal adjustment - complete.	\$25.00
OCCLUSAL ADJUSTMENT: D9951, D9952	\$100.00
• Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.	

TYPE 1 PROCEDURES
Plan 2
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

Maximum Covered
Expense \$16.00
\$16.00 \$16.00

ROUTINE ORAL EVALUATION

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

ROUTINE EVALUATION: D0120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180 also contribute(s) to this limitation.
- Coverage is subject to Combined Dental and Eye Care Exam Frequencies.

PROPHYLAXIS (CLEANING) AND FLUORIDE

- D1110 Prophylaxis - adult. \$40.00
- D1120 Prophylaxis - child. \$27.00
- D1201 Topical application of fluoride (including prophylaxis) - child. \$42.00
- D1203 Topical application of fluoride (prophylaxis not included) - child. \$15.00
- D1204 Topical application of fluoride (prophylaxis not included) - adult. \$15.00
- D1205 Topical application of fluoride (including prophylaxis) - adult. \$55.00

FLUORIDE: D1201, D1203, D1204, D1205

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- In addition, D1201, D1205 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D4355, D4910 also contribute(s) to this limitation.
- The frequency limitation will not be exceeded for either Fluoride or Prophylaxis (cleaning).

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1201, D1205, D4355, D4910 also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

FULL MOUTH DEBRIDEMENT

- D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis. \$40.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).
- D1110, D1120, D1201, D1205, D4910 also contribute(s) to this limitation.

PERIODONTAL MAINTENANCE

- D4910 Periodontal maintenance. \$40.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, D1201, D1205, D4355 also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

TYPE 2 PROCEDURES
 Plan 2
 BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
LIMITED ORAL EVALUATION	
D0140 Limited oral evaluation - problem focused.	\$16.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$16.00
LIMITED ORAL EVALUATION: D0140, D0170	
<ul style="list-style-type: none"> • Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120 and count towards this frequency. 	
COMPLETE SERIES OR PANORAMIC FILM	
D0210 Intraoral - complete series (including bitewings).	\$48.00
D0330 Panoramic film.	\$48.00
COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 3 year(s). 	
OTHER XRAYS	
D0220 Intraoral - periapical first film.	\$9.00
D0230 Intraoral - periapical each additional film.	\$9.00
D0240 Intraoral - occlusal film.	\$9.00
D0250 Extraoral - first film.	\$11.00
D0260 Extraoral - each additional film.	\$11.00
PERIAPICAL FILMS: D0220, D0230	
<ul style="list-style-type: none"> • The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210. 	
BITE WING FILMS	
D0270 Bitewing - single film.	\$9.00
D0272 Bitewings - two films.	\$18.00
D0274 Bitewings - four films.	\$18.00
D0277 Vertical bitewings - 7 to 8 films.	\$26.00
BITE WING FILMS: D0270, D0272, D0274	
<ul style="list-style-type: none"> • Coverage is limited to 2 of any of these procedures per 1 benefit period. • D0277 also contribute(s) to this limitation. • The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210. 	
VERTICAL BITE WING FILM: D0277	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 3 year(s). • The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210. 	
ORAL PATHOLOGY/LABORATORY	
D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$8.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$16.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$16.00
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). • Coverage is limited to 1 examination per biopsy/excision. 	
AMALGAM RESTORATIONS (FILLINGS)	
D2140 Amalgam - one surface, primary or permanent.	\$42.00
D2150 Amalgam - two surfaces, primary or permanent.	\$54.00
D2160 Amalgam - three surfaces, primary or permanent.	\$54.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$54.00
AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 6 month(s). • D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911 also contribute(s) to this limitation. 	
RESIN RESTORATIONS (FILLINGS)	
D2330 Resin-based composite - one surface, anterior.	\$42.00

TYPE 2 PROCEDURES

Maximum Covered
Expense

D2331 Resin-based composite - two surfaces, anterior.	\$54.00
D2332 Resin-based composite - three surfaces, anterior.	\$54.00
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).	\$54.00
D2391 Resin-based composite - one surface, posterior.	\$46.00
D2392 Resin-based composite - two surfaces, posterior.	\$60.00
D2393 Resin-based composite - three surfaces, posterior.	\$60.00
D2394 Resin-based composite - four or more surfaces, posterior.	\$66.00
D2410 Gold foil - one surface.	\$42.00
D2420 Gold foil - two surfaces.	\$54.00
D2430 Gold foil - three surfaces.	\$54.00

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

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

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.	\$54.00
D2930 Prefabricated stainless steel crown - primary tooth.	\$54.00
D293 1 Prefabricated stainless steel crown - permanent tooth.	\$54.00
D2932 Prefabricated resin crown.	\$54.00
D2933 Prefabricated stainless steel crown with resin window.	\$54.00
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.	\$54.00

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).	\$54.00
D2712 Crown - 3/4 resin-based composite (indirect).	\$202.00
D2720 Crown - resin with high noble metal.	\$54.00
D2721 Crown - resin with predominantly base metal.	\$54.00
D2722 Crown - resin with noble metal.	\$54.00

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2390, D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2930, D2931, D2932, D2933, D2934, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

SEDATIVE FILLING D2940

Sedative filling.	\$36.00
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NON-SURGICAL EXTRACTIONS

D7 111 Extraction, coronal remnants - deciduous tooth.	\$48.00
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	

SURGICAL EXTRACTIONS

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	\$48.00
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TYPE 2 PROCEDURES

Maximum Covered

	Expense
D7220 Removal of impacted tooth - soft tissue.	\$100.00
D7230 Removal of impacted tooth - partially bony.	\$100.00
D7240 Removal of impacted tooth - completely bony.	\$100.00
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.	\$125.00
D7250 Surgical removal of residual tooth roots (cutting procedure).	\$100.00

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.	\$100.00
D7261 Primary closure of a sinus perforation.	\$100.00
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$100.00
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$100.00
D7280 Surgical access of an unerupted tooth.	\$100.00
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.	\$100.00
D7283 Placement of device to facilitate eruption of impacted tooth.	\$30.00
D7310 Alveoloplasty in conjunction with extractions - per quadrant.	\$80.00
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$40.00
D7320 Alveoloplasty not in conjunction with extractions - per quadrant. D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$80.00
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).	\$100.00 \$100.00
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$100.00
D7410 Excision of benign lesion up to 1.25 cm.	\$100.00
D7411 Excision of benign lesion greater than 1.25 cm.	\$110.00
D7412 Excision of benign lesion, complicated.	\$100.00
D7413 Excision of malignant lesion up to 1.25 cm.	\$100.00
D7414 Excision of malignant lesion greater than 1.25 cm.	\$110.00
D7415 Excision of malignant lesion, complicated.	\$100.00
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm. D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.	\$100.00
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.	\$100.00
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$100.00
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$80.00
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.	\$66.00
D7473 Removal of torus mandibularis.	\$66.00
D7485 Surgical reduction of osseous tuberosity.	\$33.00
D7490 Radical resection of maxilla or mandible.	\$100.00
D7510 Incision and drainage of abscess - intraoral soft tissue. D7520 Incision and drainage of abscess - extraoral soft tissue.	\$60.00
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$80.00
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.	\$100.00
D7911 Complicated suture - up to 5 cm.	\$40.00
D7912 Complicated suture - greater than 5 cm.	\$40.00
D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure.	\$100.00
D7963 Frenuloplasty.	\$125.00
D7970 Excision of hyperplastic tissue - per arch.	\$80.00
D7972 Surgical reduction of fibrous tuberosity.	\$30.00
D7980 Sialolithotomy.	\$100.00
D7983 Closure of salivary fistula.	\$100.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

TYPE 2 PROCEDURES

	Maximum Covered Expense
BIOPSY OF ORAL TISSUE	
D7285 Biopsy of oral tissue - hard (bone, tooth).	\$80.00
D7286 Biopsy of oral tissue - soft.	\$80.00
D7287 Exfoliative cytological sample collection.	\$40.00
D7288 Brush biopsy - transepithelial sample collection.	\$40.00
PALLIATIVE	
D91 10 Palliative (emergency) treatment of dental pain - minor procedure.	\$38.00
PALLIATIVE TREATMENT: D9110	
<ul style="list-style-type: none"> • Not covered in conjunction with other procedures, except diagnostic x-ray films. 	
ANESTHESIA-GENERAL/IV	
D9220 Deep sedation/general anesthesia - first 30 minutes.	\$140.00
D9221 Deep sedation/general anesthesia - each additional 15 minutes.	\$46.00
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.	\$92.00
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.	\$22.00
GENERAL ANESTHESIA: D9220, D9221, D9241, D9242	
<ul style="list-style-type: none"> • Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered. 	
PROFESSIONAL CONSULT/VISIT/SERVICES	
D93 10 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).	\$22.00
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.	\$16.00
D9440 Office visit - after regularly scheduled hours.	\$44.00
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.	\$28.00
CONSULTATION: D9310	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 1 provider. 	
OFFICE VISIT: D9430, D9440	
<ul style="list-style-type: none"> • Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater. 	
MELANO	
US	
D295 1 Pin retention - per tooth, in addition to restoration.	\$20.00
D991 1 Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$42.00
DESENSITIZATION: D991 1	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 6 month(s). • D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394 also contribute(s) to this limitation. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations. 	

TYPE 3 PROCEDURES

Plan 2

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

Maximum Covered

INLAY RESTORATIONS

	Expense
D2510 Inlay - metallic - one surface.	\$152.00
D2520 Inlay - metallic - two surfaces.	\$188.00
D2530 Inlay - metallic - three or more surfaces.	\$188.00
D2610 Inlay - porcelain/ceramic - one surface.	\$152.00
D2620 Inlay - porcelain/ceramic - two surfaces.	\$188.00
D2630 Inlay - porcelain/ceramic - three or more surfaces.	\$188.00
D2650 Inlay - resin-based composite - one surface.	\$152.00
D2651 Inlay - resin-based composite - two surfaces.	\$188.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$188.00
INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652	

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

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.	\$272.00
D2543 Onlay - metallic - three surfaces.	\$272.00
D2544 Onlay - metallic - four or more surfaces.	\$272.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$272.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$272.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$272.00
D2662 Onlay - resin-based composite - two surfaces. D2663	\$268.00
Onlay - resin-based composite - three surfaces.	\$268.00
D2664 Onlay - resin-based composite - four or more surfaces.	\$268.00

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2390, D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2933, D2934, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

CROWNS SINGLE RESTORATIONS

D2740 Crown - porcelain/ceramic substrate.	\$224.00
D2750 Crown - porcelain fused to high noble metal.	\$224.00
D2751 Crown - porcelain fused to predominantly base metal.	\$224.00
D2752 Crown - porcelain fused to noble metal.	\$224.00
D2780 Crown - 3/4 cast high noble metal.	\$224.00
D2781 Crown - 3/4 cast predominantly base metal.	\$224.00
D2782 Crown - 3/4 cast noble metal.	\$224.00
D2783 Crown - 3/4 porcelain/ceramic.	\$224.00
D2790 Crown - full cast high noble metal.	\$224.00
D2791 Crown - full cast predominantly base metal.	\$224.00
D2792 Crown - full cast noble metal.	\$224.00
D2794 Crown - titanium.	\$224.00

RECEMENT

D2910 Recement inlay, onlay, or partial coverage restoration.	\$20.00
D2915 Recement cast or prefabricated post and core. D2920	\$10.00
Recement crown.	\$20.00
D6930 Recement fixed partial denture.	\$28.00

TYPE 3 PROCEDURES

Maximum Covered Expense

CORE BUILD-UP

D2950	Core buildup, including any pins.	\$56.00
D6973	Core build up for retainer, including any pins.	\$56.00

POST AND CORE

D2952	Cast post and core in addition to crown.	\$84.00
D2954	Prefabricated post and core in addition to crown.	\$72.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	\$60.00
D6980	Fixed partial denture repair, by report.	\$68.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$38.00
D3221	Pulpal debridement, primary and permanent teeth.	\$38.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$160.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$160.00
D3333	Internal root repair of perforation defects.	\$60.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$60.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	\$50.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	\$50.00
D3430	Retrograde filling - per root.	\$56.00
D3450	Root amputation - per root.	\$88.00
D3920	Hemisection (including any root removal), not including root canal therapy.	\$88.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240

- Procedure D3220 is limited to primary teeth.

ENDODONTIC

C THERAPY (ROOT CANALS)

D3310	Anterior (excluding final restoration).	\$160.00
D3320	Bicuspid (excluding final restoration).	\$180.00
D3330	Molar (excluding final restoration).	\$240.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$90.00
D3346	Retreatment of previous root canal therapy - anterior.	\$160.00
D3347	Retreatment of previous root canal therapy - bicuspid.	\$180.00
D3348	Retreatment of previous root canal therapy - molar.	\$240.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330 also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	\$180.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	\$180.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	\$180.00
D3426	Apicoectomy/periradicular surgery (each additional root).	\$60.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$120.00
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TYPE 3 PROCEDURES

Maximum Covered
Expense

D421 1	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$60.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$140.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$70.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$300.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$150.00
D4263	Bone replacement graft - first site in quadrant.	\$104.00
D4264	Bone replacement graft - each additional site in quadrant.	\$124.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	\$52.00
D4270	Pedicle soft tissue graft procedure.	\$180.00
D4271	Free soft tissue graft procedure (including donor site surgery).	\$200.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	\$200.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	\$30.00
D4275	Soft tissue allograft.	\$200.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	\$200.00

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

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

CROWN LENGTHENING

D4249	Clinical crown lengthening - hard tissue.	\$112.00
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NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	\$52.
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crevicular tissue, per tooth, by report.

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).
- A scaling and root planing or periodontal maintenance procedure must be performed in this quadrant within 2 years prior to the date of service for this procedure.

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5 110	Complete denture - maxillary.	\$300.00
D5120	Complete denture - mandibular.	\$300.00
D5130	Immediate denture - maxillary.	\$300.00
D5140	Immediate denture - mandibular.	\$300.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	\$300.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	\$300.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$300.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$300.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	\$300.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	\$300.00

TYPE 3 PROCEDURES

Maximum Covered
Expense

D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	\$200.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	\$300.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	\$300.00
D5810	Interim complete denture (maxillary).	\$140.00
D5811	Interim complete denture (mandibular).	\$140.00
D5820	Interim partial denture (maxillary).	\$112.00
D5821	Interim partial denture (mandibular).	\$112.00
D5860	Overdenture - complete, by report.	\$300.00
D5861	Overdenture - partial, by report.	\$300.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	\$300.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	\$300.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	\$300.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	\$300.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	\$20.00
D5411	Adjust complete denture - mandibular.	\$20.00
D5421	Adjust partial denture - maxillary. D5422	\$20.00
	Adjust partial denture - mandibular.	\$20.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	\$36.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	\$34.00
D5610	Repair resin denture base.	\$36.00
D5620	Repair cast framework.	\$36.00
D5630	Repair or replace broken clasp.	\$36.00
D5640	Replace broken teeth - per tooth.	\$34.00

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	\$36.00
D5660	Add clasp to existing partial denture.	

DENTURE REBASES

D5710	Rebase complete maxillary denture. D5711	\$40.00
D5720	Rebase complete mandibular denture. D5721	
D5721	Rebase maxillary partial denture. D5722	\$96.00
D5722	Rebase mandibular partial denture.	\$96.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside). D5731	\$48.00
D5740	Reline complete mandibular denture (chairside). D5741	\$48.00
D5741	Reline maxillary partial denture (chairside). D5742	\$48.00
D5750	Reline mandibular partial denture (chairside). D5751	\$48.00
D5751	Reline complete maxillary denture (laboratory). D5752	\$88.00
D5760	Reline complete mandibular denture (laboratory). D5761	\$88.00
D5761	Reline maxillary partial denture (laboratory). D5762	\$88.00
D5762	Reline mandibular partial denture (laboratory).	\$88.00

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

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

TYPE 3 PROCEDURES

	Maximum Covered Expense
TISSUE CONDITIONING	
D5850 Tissue conditioning, maxillary.	\$26.00
D5851 Tissue conditioning, mandibular.	\$26.00
PROSTHODONTICS - FIXED	
D6058 Abutment supported porcelain/ceramic crown.	\$224.00
D6059 Abutment supported porcelain fused to metal crown (high noble metal).	\$224.00
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).	\$224.00
D6061 Abutment supported porcelain fused to metal crown (noble metal).	\$224.00
D6062 Abutment supported cast metal crown (high noble metal).	\$224.00
D6063 Abutment supported cast metal crown (predominantly base metal).	\$224.00
D6064 Abutment supported cast metal crown (noble metal).	\$224.00
D6065 Implant supported porcelain/ceramic crown.	\$224.00
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	\$224.00
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).	\$224.00
D6068 Abutment supported retainer for porcelain/ceramic FPD.	\$224.00
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	\$224.00
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	\$224.00
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).	\$224.00
D6072 Abutment supported retainer for cast metal FPD (high noble metal).	\$224.00
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).	\$224.00
D6074 Abutment supported retainer for cast metal FPD (noble metal).	\$224.00
D6075 Implant supported retainer for ceramic FPD.	\$224.00
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	\$224.00
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	\$224.00
D6094 Abutment supported crown - (titanium).	\$224.00
D6194 Abutment supported retainer crown for FPD - (titanium).	\$224.00
D6205 Pontic - indirect resin based composite.	\$202.00
D6210 Pontic - cast high noble metal.	\$224.00
D621 1 Pontic - cast predominantly base metal.	\$224.00
D6212 Pontic - cast noble metal.	\$224.00
D6214 Pontic - titanium.	\$224.00
D6240 Pontic - porcelain fused to high noble metal.	\$224.00
D6241 Pontic - porcelain fused to predominantly base metal.	\$224.00
D6242 Pontic - porcelain fused to noble metal.	\$224.00
D6245 Pontic - porcelain/ceramic.	\$224.00
D6250 Pontic - resin with high noble metal.	\$224.00
D6251 Pontic - resin with predominantly base metal.	\$224.00
D6252 Pontic - resin with noble metal.	\$224.00
D6545 Retainer - cast metal for resin bonded fixed prosthesis.	\$112.00
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	\$112.00
D6600 Inlay - porcelain/ceramic, two surfaces.	\$188.00
D6601 Inlay - porcelain/ceramic, three or more surfaces.	\$207.00
D6602 Inlay - cast high noble metal, two surfaces.	\$207.00
D6603 Inlay - cast high noble metal, three or more surfaces.	\$228.00
D6604 Inlay - cast predominantly base metal, two surfaces.	\$179.00
D6605 Inlay - cast predominantly base metal, three or more surfaces.	\$197.00
D6606 Inlay - cast noble metal, two surfaces.	\$188.00
D6607 Inlay - cast noble metal, three or more surfaces.	\$207.00
D6608 Onlay - porcelain/ceramic, two surfaces.	\$272.00
D6609 Onlay - porcelain/ceramic, three or more surfaces.	\$299.00
D6610 Onlay - cast high noble metal, two surfaces.	\$228.00
D661 1 Onlay - cast high noble metal, three or more surfaces.	\$250.00
D6612 Onlay - cast predominantly base metal, two surfaces.	\$197.00
D6613 Onlay - cast predominantly base metal, three or more surfaces.	\$216.00
D6614 Onlay - cast noble metal, two surfaces.	\$207.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D6615 Onlay - cast noble metal, three or more surfaces. D6624 Inlay - titanium.	\$228.00
D6634 Onlay - titanium.	\$228.00
D6710 Crown - indirect resin based composite. D6720 Crown - resin with high noble metal.	\$250.00
D6721 Crown - resin with predominantly base metal. D6722 Crown - resin with noble metal. D6740 Crown - porcelain/ceramic.	\$202.00
D6750 Crown - porcelain fused to high noble metal.	\$224.00
D6751 Crown - porcelain fused to predominantly base metal.	\$224.00
D6752 Crown - porcelain fused to noble metal. D6780 Crown - 3/4 cast high noble metal. D6781 Crown - 3/4 cast predominantly base metal. D6782 Crown - 3/4 cast noble metal.	\$224.00
D6783 Crown - 3/4 porcelain/ceramic.	\$224.00
D6790 Crown - full cast high noble metal.	\$224.00
D6791 Crown - full cast predominantly base metal. D6792 Crown - full cast noble metal.	\$224.00
D6794 Crown - titanium.	\$224.00
D6940 Stress breaker.	\$224.00
FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6790, D6791, D6792, D6794	\$60.00
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s) D2390, D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2933, D2934, 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. 	
FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D2390, D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2933, D2934, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194 also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252 also contribute(s) to this limitation. • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252 also contribute(s) to this limitation. 	

TYPE 3 PROCEDURES

Maximum Covered
Expense

- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970 Cast post and core in addition to fixed partial denture retainer.	
D697 1 Cast post as part of fixed partial denture retainer.	\$80.00
D6972 Prefabricated post and core in addition to fixed partial denture retainer.	\$70.00
	\$70.00

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.	
D9952 Occlusal adjustment - complete.	\$20.00
OCCLUSAL ADJUSTMENT: D9951, D9952	\$80.00
• Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.	

TYPE 1 PROCEDURES
Plan 3
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

Maximum Covered
Expense \$12.00

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation.

\$12.00

D0150 Comprehensive oral evaluation - new or established patient.

\$12.00

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

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

ROUTINE EVALUATION: D0120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180 also contribute(s) to this limitation.
- Coverage is subject to Combined Dental and Eye Care Exam Frequencies.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.

\$30.00

D1120 Prophylaxis - child.

\$20.00

D1201 Topical application of fluoride (including prophylaxis) - child.

\$32.00

D1203 Topical application of fluoride (prophylaxis not included) - child.

\$11.00

D1204 Topical application of fluoride (prophylaxis not included) - adult.

\$11.00

D1205 Topical application of fluoride (including prophylaxis) - adult.

\$41.00

FLUORIDE: D1201, D1203, D1204, D1205

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- In addition, D1201, D1205 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D4355, D4910 also contribute(s) to this limitation.
- The frequency limitation will not be exceeded for either Fluoride or Prophylaxis (cleaning).

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1201, D1205, D4355, D4910 also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

\$30.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).
- D1110, D1120, D1201, D1205, D4910 also contribute(s) to this limitation.

PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance.

\$30.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, D1201, D1205, D4355 also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

TYPE 2 PROCEDURES
 Plan 3
 BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

	Maximum Covered Expense
LIMITED ORAL EVALUATION	
D0140 Limited oral evaluation - problem focused.	\$12.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$12.00
LIMITED ORAL EVALUATION: D0140, D0170	
<ul style="list-style-type: none"> • Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120 and count towards this frequency. 	
COMPLETE SERIES OR PANORAMIC FILM	
D0210 Intraoral - complete series (including bitewings).	\$36.00
D0330 Panoramic film.	\$36.00
COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 3 year(s). 	
OTHER XRAYS	
D0220 Intraoral - periapical first film.	\$7.00
D0230 Intraoral - periapical each additional film.	\$7.00
D0240 Intraoral - occlusal film.	\$7.00
D0250 Extraoral - first film.	\$8.00
D0260 Extraoral - each additional film.	\$8.00
PERIAPICAL FILMS: D0220, D0230	
<ul style="list-style-type: none"> • The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210. 	
BITE WING FILMS	
D0270 Bitewing - single film.	\$7.00
D0272 Bitewings - two films.	\$13.00
D0274 Bitewings - four films.	\$13.00
D0277 Vertical bitewings - 7 to 8 films.	\$20.00
BITE WING FILMS: D0270, D0272, D0274	
<ul style="list-style-type: none"> • Coverage is limited to 2 of any of these procedures per 1 benefit period. • D0277 also contribute(s) to this limitation. • The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210. 	
VERTICAL BITE WING FILM: D0277	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 3 year(s). • The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210. 	
ORAL PATHOLOGY/LABORATORY	
D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$6.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$12.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$12.00
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). • Coverage is limited to 1 examination per biopsy/excision. 	
AMALGAM RESTORATIONS (FILLINGS)	
D2140 Amalgam - one surface, primary or permanent.	\$32.00
D2150 Amalgam - two surfaces, primary or permanent.	\$41.00
D2160 Amalgam - three surfaces, primary or permanent.	\$41.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$41.00
AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 6 month(s). • D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911 also contribute(s) to this limitation. 	
RESIN RESTORATIONS (FILLINGS)	
D2330 Resin-based composite - one surface, anterior.	\$32.00

TYPE 2 PROCEDURES

Maximum Covered
Expense

D2331 Resin-based composite - two surfaces, anterior.	\$41.00
D2332 Resin-based composite - three surfaces, anterior.	\$41.00
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).	\$41.00
D2391 Resin-based composite - one surface, posterior.	\$35.00
D2392 Resin-based composite - two surfaces, posterior.	\$45.00
D2393 Resin-based composite - three surfaces, posterior.	\$45.00
D2394 Resin-based composite - four or more surfaces, posterior.	\$49.00
D2410 Gold foil - one surface.	\$32.00
D2420 Gold foil - two surfaces.	\$41.00
D2430 Gold foil - three surfaces.	\$41.00

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

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

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.	\$41.00
D2930 Prefabricated stainless steel crown - primary tooth.	\$41.00
D293 1 Prefabricated stainless steel crown - permanent tooth.	\$41.00
D2932 Prefabricated resin crown.	\$41.00
D2933 Prefabricated stainless steel crown with resin window.	\$41.00
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.	\$41.00

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).	\$41.00
D2712 Crown - 3/4 resin-based composite (indirect).	\$151.00
D2720 Crown - resin with high noble metal.	\$41.00
D2721 Crown - resin with predominantly base metal.	\$41.00
D2722 Crown - resin with noble metal.	\$41.00

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

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2390, D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2930, D2931, D2932, D2933, D2934, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

SEDATIVE FILLING D2940

Sedative filling.	\$27.00
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NON-SURGICAL EXTRACTIONS

D7 111 Extraction, coronal remnants - deciduous tooth.	\$36.00
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	

SURGICAL EXTRACTIONS

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	\$36.00
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TYPE 2 PROCEDURES

Maximum Covered
Expense
\$75.00

D7220	Removal of impacted tooth - soft tissue.	\$75.00
D7230	Removal of impacted tooth - partially bony.	\$75.00
D7240	Removal of impacted tooth - completely bony.	\$75.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	\$94.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	\$75.00

OTHER ORAL SURGERY

D7260	Oroantral fistula closure.	\$75.00
D7261	Primary closure of a sinus perforation.	\$75.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$75.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$75.00
D7280	Surgical access of an unerupted tooth.	\$75.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	\$75.00
D7283	Placement of device to facilitate eruption of impacted tooth.	\$23.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant.	\$60.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$30.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant. D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	\$60.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	\$75.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$75.00
D7410	Excision of benign lesion up to 1.25 cm.	
D7411	Excision of benign lesion greater than 1.25 cm.	\$75.00
D7412	Excision of benign lesion, complicated.	\$75.00
D7413	Excision of malignant lesion up to 1.25 cm.	\$83.00
D7414	Excision of malignant lesion greater than 1.25 cm.	\$75.00
D7415	Excision of malignant lesion, complicated.	\$75.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm. D7441	\$83.00
	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	\$75.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm. D7451	\$75.00
	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$75.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	\$75.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	\$75.00
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.	\$75.00
		\$60.00
D7473	Removal of torus mandibularis.	\$50.00
D7485	Surgical reduction of osseous tuberosity.	\$50.00
D7490	Radical resection of maxilla or mandible.	\$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue. D7520 Incision and drainage of abscess - extraoral soft tissue.	\$25.00
		\$75.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$45.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system. D7550	\$75.00
	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.	\$60.00
		\$75.00
D7911	Complicated suture - up to 5 cm.	\$75.00
D7912	Complicated suture - greater than 5 cm.	\$30.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	\$30.00
D7963	Frenuloplasty.	\$30.00
D7970	Excision of hyperplastic tissue - per arch.	\$75.00
D7972	Surgical reduction of fibrous tuberosity.	\$94.00
D7980	Sialolithotomy.	\$60.00
D7983	Closure of salivary fistula.	\$23.00
	REMOVAL OF BONE TISSUE: D7471, D7472, D7473	\$75.00

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

TYPE 2 PROCEDURES

	Maximum Covered Expense
BIOPSY OF ORAL TISSUE	
D7285 Biopsy of oral tissue - hard (bone, tooth).	\$60.00
D7286 Biopsy of oral tissue - soft.	\$60.00
D7287 Exfoliative cytological sample collection.	\$30.00
D7288 Brush biopsy - transepithelial sample collection.	\$30.00
PALLIATIVE	
D91 10 Palliative (emergency) treatment of dental pain - minor procedure.	\$29.00
PALLIATIVE TREATMENT: D9110	
<ul style="list-style-type: none"> • Not covered in conjunction with other procedures, except diagnostic x-ray films. 	
ANESTHESIA-GENERAL/IV	
D9220 Deep sedation/general anesthesia - first 30 minutes.	\$105.00
D9221 Deep sedation/general anesthesia - each additional 15 minutes.	\$35.00
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.	\$69.00
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.	\$17.00
GENERAL ANESTHESIA: D9220, D9221, D9241, D9242	
<ul style="list-style-type: none"> • Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered. 	
PROFESSIONAL CONSULT/VISIT/SERVICES	
D93 10 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).	\$17.00
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.	\$12.00
D9440 Office visit - after regularly scheduled hours.	\$33.00
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.	\$21.00
CONSULTATION: D9310	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 1 provider. 	
OFFICE VISIT: D9430, D9440	
<ul style="list-style-type: none"> • Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater. 	
MELANO	
US	
D295 1 Pin retention - per tooth, in addition to restoration.	\$15.00
D991 1 Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$32.00
DESENSITIZATION: D991 1	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 6 month(s). • D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394 also contribute(s) to this limitation. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. • Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations. 	

TYPE 3 PROCEDURES

Plan 3

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

	Maximum Covered
INLAY RESTORATIONS	Expense
D2510 Inlay - metallic - one surface.	\$114.00
D2520 Inlay - metallic - two surfaces.	\$141.00
D2530 Inlay - metallic - three or more surfaces.	\$141.00
D2610 Inlay - porcelain/ceramic - one surface.	\$114.00
D2620 Inlay - porcelain/ceramic - two surfaces.	\$141.00
D2630 Inlay - porcelain/ceramic - three or more surfaces.	\$141.00
D2650 Inlay - resin-based composite - one surface.	\$114.00
D265 1 Inlay - resin-based composite - two surfaces.	\$141.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$141.00
INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652	
<ul style="list-style-type: none">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.	\$204.00
D2543 Onlay - metallic - three surfaces.	\$204.00
D2544 Onlay - metallic - four or more surfaces.	\$204.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$204.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$204.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$204.00
D2662 Onlay - resin-based composite - two surfaces. D2663	\$201.00
Onlay - resin-based composite - three surfaces.	\$201.00
D2664 Onlay - resin-based composite - four or more surfaces.	\$201.00
ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664	
<ul style="list-style-type: none">Replacement is limited to 1 of any of these procedures per 5 year(s).D2390, D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2933, D2934, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.Frequency is waived for accidental injury.Porcelain and resin benefits are considered for anterior and bicuspid teeth only.Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.	
CROWNS SINGLE RESTORATIONS	
D2740 Crown - porcelain/ceramic substrate.	\$168.00
D2750 Crown - porcelain fused to high noble metal.	\$168.00
D2751 Crown - porcelain fused to predominantly base metal.	\$168.00
D2752 Crown - porcelain fused to noble metal.	\$168.00
D2780 Crown - 3/4 cast high noble metal.	\$168.00
D2781 Crown - 3/4 cast predominantly base metal.	\$168.00
D2782 Crown - 3/4 cast noble metal.	\$168.00
D2783 Crown - 3/4 porcelain/ceramic.	\$168.00
D2790 Crown - full cast high noble metal.	\$168.00
D2791 Crown - full cast predominantly base metal.	\$168.00
D2792 Crown - full cast noble metal.	\$168.00
D2794 Crown - titanium.	\$168.00
RECEMENT	
D2910 Recement inlay, onlay, or partial coverage restoration.	\$15.00
D2915 Recement cast or prefabricated post and core. D2920	\$8.00
Recement crown.	\$15.00
D6930 Recement fixed partial denture.	\$21.00

TYPE 3 PROCEDURES

Maximum Covered Expense

CORE BUILD-UP

D2950	Core buildup, including any pins.	\$42.00
D6973	Core build up for retainer, including any pins.	\$42.00

POST AND CORE

D2952	Cast post and core in addition to crown.	\$63.00
D2954	Prefabricated post and core in addition to crown.	\$54.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	\$45.00
D6980	Fixed partial denture repair, by report.	\$51.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$29.00
D3221	Pulpal debridement, primary and permanent teeth.	\$29.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$120.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$120.00
D3333	Internal root repair of perforation defects.	\$45.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$45.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	\$38.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	\$38.00
D3430	Retrograde filling - per root.	\$42.00
D3450	Root amputation - per root.	\$66.00
D3920	Hemisection (including any root removal), not including root canal therapy.	\$66.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240

- Procedure D3220 is limited to primary teeth.

ENDODONTIC

C THERAPY (ROOT CANALS)

D3310	Anterior (excluding final restoration).	\$120.00
D3320	Bicuspid (excluding final restoration).	\$135.00
D3330	Molar (excluding final restoration).	\$180.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$ 68.00
D3346	Retreatment of previous root canal therapy - anterior.	\$120.00
D3347	Retreatment of previous root canal therapy - bicuspid.	\$135.00
D3348	Retreatment of previous root canal therapy - molar.	\$180.00

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330 also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	\$135.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	\$135.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	\$135.00
D3426	Apicoectomy/periradicular surgery (each additional root).	\$45.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$90.00
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TYPE 3 PROCEDURES

Maximum Covered
Expense

D421 1	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$45.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$105.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$53.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.	\$225.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.	\$113.00
D4263	Bone replacement graft - first site in quadrant.	\$78.00
D4264	Bone replacement graft - each additional site in quadrant.	\$93.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	\$39.00
D4270	Pedicle soft tissue graft procedure.	\$135.00
D4271	Free soft tissue graft procedure (including donor site surgery).	\$150.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	\$150.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	\$23.00
D4275	Soft tissue allograft.	\$150.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	\$150.00

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

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

CROWN LENGTHENING

D4249	Clinical crown lengthening - hard tissue.	\$84.00
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NON-SURGICAL PERIODONTICS

D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	\$39.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	\$20.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	\$32.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).
- A scaling and root planing or periodontal maintenance procedure must be performed in this quadrant within 2 years prior to the date of service for this procedure.

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5 110	Complete denture - maxillary.	\$225.00
D5120	Complete denture - mandibular.	\$225.00
D5130	Immediate denture - maxillary.	\$225.00
D5140	Immediate denture - mandibular.	\$225.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	\$225.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	\$225.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$225.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$225.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	\$225.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	\$225.00

TYPE 3 PROCEDURES

Maximum Covered
Expense

D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	\$150.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	\$225.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	\$225.00
D5810	Interim complete denture (maxillary).	\$105.00
D5811	Interim complete denture (mandibular).	\$105.00
D5820	Interim partial denture (maxillary).	\$84.00
D5821	Interim partial denture (mandibular).	\$84.00
D5860	Overdenture - complete, by report.	\$225.00
D5861	Overdenture - partial, by report.	\$225.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	\$225.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	\$225.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	\$225.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	\$225.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture - maxillary.	\$15.00
D5411	Adjust complete denture - mandibular.	\$15.00
D5421	Adjust partial denture - maxillary. D5422	\$15.00
	Adjust partial denture - mandibular.	\$15.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

DENTURE REPAIR

D5510	Repair broken complete denture base.	\$27.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	\$26.00
D5610	Repair resin denture base.	\$27.00
D5620	Repair cast framework.	\$27.00
D5630	Repair or replace broken clasp.	\$27.00
D5640	Replace broken teeth - per tooth.	\$26.00

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	\$27.00
D5660	Add clasp to existing partial denture.	

DENTURE REBASES

D5710	Rebase complete maxillary denture. D5711	\$30.00
D5720	Rebase complete mandibular denture. D5721	
D5721	Rebase maxillary partial denture. D5722	\$72.00
D5722	Rebase mandibular partial denture.	\$72.00

DENTURE RELINES

D5730	Reline complete maxillary denture (chairside). D5731	\$36.00
D5740	Reline complete mandibular denture (chairside). D5741	\$36.00
D5741	Reline maxillary partial denture (chairside). D5742	\$36.00
D5750	Reline mandibular partial denture (chairside). D5751	\$36.00
D5751	Reline complete maxillary denture (laboratory). D5752	\$66.00
D5760	Reline complete mandibular denture (laboratory). D5761	\$66.00
D5761	Reline maxillary partial denture (laboratory). D5762	\$66.00
D5762	Reline mandibular partial denture (laboratory).	\$66.00

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

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

TYPE 3 PROCEDURES

	Maximum Covered Expense
TISSUE CONDITIONING	
D5850 Tissue conditioning, maxillary.	\$20.00
D5851 Tissue conditioning, mandibular.	\$20.00
PROSTHODONTICS - FIXED	
D6058 Abutment supported porcelain/ceramic crown.	\$168.00
D6059 Abutment supported porcelain fused to metal crown (high noble metal).	\$168.00
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).	\$168.00
D6061 Abutment supported porcelain fused to metal crown (noble metal).	\$168.00
D6062 Abutment supported cast metal crown (high noble metal).	\$168.00
D6063 Abutment supported cast metal crown (predominantly base metal).	\$168.00
D6064 Abutment supported cast metal crown (noble metal).	\$168.00
D6065 Implant supported porcelain/ceramic crown.	\$168.00
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	\$168.00
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).	\$168.00
D6068 Abutment supported retainer for porcelain/ceramic FPD.	\$168.00
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	\$168.00
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	\$168.00
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).	\$168.00
D6072 Abutment supported retainer for cast metal FPD (high noble metal).	\$168.00
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).	\$168.00
D6074 Abutment supported retainer for cast metal FPD (noble metal).	\$168.00
D6075 Implant supported retainer for ceramic FPD.	\$168.00
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	\$168.00
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	\$168.00
D6094 Abutment supported crown - (titanium).	\$168.00
D6194 Abutment supported retainer crown for FPD - (titanium).	\$168.00
D6205 Pontic - indirect resin based composite.	\$151.00
D6210 Pontic - cast high noble metal.	\$168.00
D621 1 Pontic - cast predominantly base metal.	\$168.00
D6212 Pontic - cast noble metal.	\$168.00
D6214 Pontic - titanium.	\$168.00
D6240 Pontic - porcelain fused to high noble metal.	\$168.00
D6241 Pontic - porcelain fused to predominantly base metal.	\$168.00
D6242 Pontic - porcelain fused to noble metal.	\$168.00
D6245 Pontic - porcelain/ceramic.	\$168.00
D6250 Pontic - resin with high noble metal.	\$168.00
D6251 Pontic - resin with predominantly base metal.	\$168.00
D6252 Pontic - resin with noble metal.	\$168.00
D6545 Retainer - cast metal for resin bonded fixed prosthesis.	\$84.00
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	\$84.00
D6600 Inlay - porcelain/ceramic, two surfaces.	\$141.00
D6601 Inlay - porcelain/ceramic, three or more surfaces.	\$155.00
D6602 Inlay - cast high noble metal, two surfaces.	\$155.00
D6603 Inlay - cast high noble metal, three or more surfaces.	\$171.00
D6604 Inlay - cast predominantly base metal, two surfaces.	\$134.00
D6605 Inlay - cast predominantly base metal, three or more surfaces.	\$148.00
D6606 Inlay - cast noble metal, two surfaces.	\$141.00
D6607 Inlay - cast noble metal, three or more surfaces.	\$155.00
D6608 Onlay - porcelain/ceramic, two surfaces.	\$204.00
D6609 Onlay - porcelain/ceramic, three or more surfaces.	\$224.00
D6610 Onlay - cast high noble metal, two surfaces.	\$171.00
D661 1 Onlay - cast high noble metal, three or more surfaces.	\$188.00
D6612 Onlay - cast predominantly base metal, two surfaces.	\$148.00
D6613 Onlay - cast predominantly base metal, three or more surfaces.	\$162.00
D6614 Onlay - cast noble metal, two surfaces.	\$155.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D6615 Onlay - cast noble metal, three or more surfaces. D6624 Inlay - titanium.	\$171.00
D6634 Onlay - titanium.	\$171.00
D6710 Crown - indirect resin based composite. D6720 Crown - resin with high noble metal.	\$188.00
D6721 Crown - resin with predominantly base metal. D6722 Crown - resin with noble metal. D6740 Crown - porcelain/ceramic.	\$151.00
D6750 Crown - porcelain fused to high noble metal.	\$168.00
D6751 Crown - porcelain fused to predominantly base metal.	\$168.00
D6752 Crown - porcelain fused to noble metal. D6780 Crown - 3/4 cast high noble metal. D6781 Crown - 3/4 cast predominantly base metal. D6782 Crown - 3/4 cast noble metal.	\$168.00
D6783 Crown - 3/4 porcelain/ceramic.	\$168.00
D6790 Crown - full cast high noble metal.	\$168.00
D6791 Crown - full cast predominantly base metal. D6792 Crown - full cast noble metal.	\$168.00
D6794 Crown - titanium.	\$168.00
D6940 Stress breaker.	\$168.00
FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6790, D6791, D6792, D6794	\$45.00
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s) D2390, D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2933, D2934, 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. 	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	
IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194	
<ul style="list-style-type: none"> • Replacement is limited to 1 of any of these procedures per 5 year(s). • Frequency is waived for accidental injury. • Porcelain and resin benefits are considered for anterior and bicuspid teeth only. 	

TYPE 3 PROCEDURES

- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Maximum Covered
Expense

CAST POST AND CORE FOR PARTIALS

D6970 Cast post and core in addition to fixed partial denture retainer.	
D697 1 Cast post as part of fixed partial denture retainer.	\$60.00
D6972 Prefabricated post and core in addition to fixed partial denture retainer.	\$53.00
	\$53.00

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.	
D9952 Occlusal adjustment - complete.	\$15.00
OCCLUSAL ADJUSTMENT: D9951, D9952	\$60.00
• Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.	

Reimbursements

www.fedvp.com Email:

info@fedvp.com

Any Vision Office Savings

See a PPO Vision Office for

Dr. Expensive, Costco, Even your HMO Provider

Exam \$ 45

Discount with PPO

Providers

Reimbursement Amount

Maximum Fee

Member

Pays

Eye Med Providers

Single Vision	\$ 40	\$ 50	\$ 10
Bifocal	\$ 60	\$ 70	\$ 10
Trifocal	\$ 75	\$ 105	\$ 30
Contacts	\$120		

No line bifocal

or progressive power \$ 80

Frames \$ 80

35% off retail a \$200 pair of

glasses

available stock 35% off price =\$

130

\$130 minus \$80 Reimbursement = \$50 Out of Pocket

\$10 Lenses

\$50 for those \$ 200

Frames

\$60 total cost member cost for a \$400 Pair of Glasses

We Fix the Maximum Cost for all those

Extras

Lens Options

No Over

Charging:

UV Coating	\$ 15
Tint (Solid and Gradient)	\$ 15
Standard Scratch-Resistance	\$ 15
Standard Polycarbonate	\$ 40
Standard Progressive (Add-on to Bifocal)	\$ 65
Standard Anti-Reflective Coating	\$ 45

Frequency Allowance Exam 12 Months Lens 12 Months Frames 24 Months

Eye Med Fusion Discount Overlay Benefit Design Summary Access Plan D
Discounted Exam Benefit and a Defined Materials Discount Benefit

Limitations, Exclusions and Elimination Periods

Vision Care Services

Member Cost

Exam with Dilation as Necessary:
exam

\$10 off contact lens

\$5 off routine exam

Complete Pair Glasses Purchase**: Frame, lenses and lens options purchased in same transaction

Standard Plastic Lenses**:

Single Vision	\$50
Bifocal	\$70
Trifocal	\$105

Frames:

Any frame available at provider location 35% off retail price

Lens Options:

UV Coating	\$15
Tint (Solid and Gradient)	\$15
Standard Scratch-Resistance	\$15
Standard Polycarbonate	\$40
Standard Progressive (Add-on to Bifocal)	\$65
Standard Anti-Reflective Coating	\$45

Contact Lenses (1):

(Discount applied to materials only)

Conventional 15% off retail price

Laser Vision Correction:

15% off retail price – or

-

Lasik or PRK
price

5% off promotional

Frequency:

Examinations:	Unlimited
Frame	Unlimited
Lenses	Unlimited
Contact Lenses	Unlimited

**The 35% discount is only available when a complete pair of glasses is purchased.

Items purchased separately will be discounted 20% off the retail price.

- (1) After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedcissioncare.com. The contact lens benefit allowance is applicable to this services

Member will receive a 20% discount on items purchased at participating Providers not included under plan coverage. 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location.

Plan Limitations/Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Corrective eyewear required by an employer as a condition of employment
- Services provided as a result of any Worker's Compensation law
- Plano non-prescription lenses and non prescription sun glasses (except for 20% discount)
- Two pair of glasses in lieu of bifocals

Administrator: www.fedvp.com email info@fedvp.com

LIMITATIONS. Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. vision examinations more than the frequency as indicated on the plan definition page.
2. lenses more than the frequency as indicated on the plan definition page.
3. frames more than the frequency as indicated on the plan definition page.
4. contact lenses more than once in any twelve month period. When chosen, contact lenses shall be in lieu of any other lens or frames benefit during the twelve month period. When lenses and frames are chosen, expenses for contact lenses are not Covered Expenses during the twelve month period.
5. examinations performed or frames or lenses ordered before the Insured was covered under the eye care expense benefits.
6. subject to extension of benefits, any examination performed or frame or lens ordered after the insured's coverage under the eye care expense benefits ceases.
7. sub-normal eye care aids; orthoptic or eye care training or any associated testing.
8. non-prescription lenses.
9. replacement or repair of lost or broken lenses or frames except at normal intervals.
10. any eye examination or corrective eyewear required by an employer as condition of employment.
11. medical or surgical treatment of the eyes.

12. any service or supply not shown on the Schedule of Eye Care Procedures.
13. coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.
14. lenses and frames during the first twelve months that a person is insured under the eye care expense benefits, when the person is a Late Entrant, clients who drop out and wish to reenroll as defined.