

This is important information on changes in your Brand New Day Plan information.

Changes to your 2023 Annual Notice of Changes, Evidence of Coverage and Summary of Benefits:

Where you can find the change in your 2023 Materials:	Original information:	Corrected information:	What does this mean to you?
<p>Annual Notice of Change - Changes to Benefits and Costs for Medical Services - Medicare Part B Prescription Drugs</p>	<p>Not included</p>	<p>2022: You pay 20% coinsurance</p> <p>2023: You pay up to 20% coinsurance.</p> <p>Certain rebatable drugs may be subject to a lower coinsurance. Part B insulin cost sharing is no more than a \$35 copay for a one-month supply.</p>	<p>You pay up to 20% coinsurance for Medicare Part B Drugs, and no more than a \$35 copay for a one-month supply of Medicare Part B insulin.</p>
<p>Evidence of Coverage - Chapter 4, Section 2.1 Your medical benefits and costs as a member of the plan - Medicare Part B Prescription Drugs</p>	<p>You pay 20% coinsurance</p>	<p>You pay up to 20% coinsurance. Certain rebatable drugs may be subject to a lower coinsurance. Part B insulin cost sharing is no more than a \$35 copay for a one-month supply.</p>	<p>You pay up to 20% coinsurance for Medicare Part B Drugs, and no more than a \$35 copay for a one-month supply of Medicare Part B insulin.</p>

<p>Summary of Benefits - Medicare Part B Drugs</p> <ul style="list-style-type: none"> • Chemotherapy drugs • Other Part B drugs 	<ul style="list-style-type: none"> • 20% coinsurance • 20% coinsurance 	<ul style="list-style-type: none"> • Up to 20% coinsurance • Up to 20% coinsurance. Part B insulin cost sharing is no more than a \$35 copay for a one-month supply 	<p>You pay up to 20% coinsurance for Medicare Part B Drugs, and no more than a \$35 copay for a one-month supply of Medicare Part B insulin.</p>
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You are not required to take any action in response to this document, but we recommend you keep this information for future reference.

If you have any questions, please call us at 1-866-255-4795 (TTY users should call 711.). Hours are 8:00 am to 8:00 pm 7 days a week from October 1 - March 31 and 8:00 am to 8:00 pm Monday - Friday from April 1 - September 30.

Brand New Day is an HMO plan with a Medicare contract. Enrollment in this plan depends on contract renewal.

brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

DENTAL BENEFITS ADDENDUM

**BRAND NEW DAY
HEALTH PLAN**

Enhanced Mandatory Option 2
CAC39

Administered by:



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INTRODUCTION

We are pleased to welcome you to the dental plan for BRAND NEW DAY. Your plan is administered by Delta Dental of California (“Delta Dental”). Our goal is to provide you with high quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

This plan is available in the following counties: Alameda, Contra Costa, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Stanislaus, Tulare and Yolo.

Using This Evidence of Coverage

This Dental Benefit Addendum (“Plan”), which includes Attachment A, Schedule of Copayments and Attachment B, Services, Limitations and Exclusions, discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the Plan works and how to obtain dental care. Please read this booklet completely and carefully. Please read the Definitions section, which will explain any words that have special or technical meanings in this Plan.

The benefit explanations contained in this Plan booklet are subject to all provisions of the Contract on file with BRAND NEW DAY (“Contractholder”) and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Notice: *This Plan booklet is a summary of your dental plan, and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered Benefits, services or payments.*

Contact Us

For more information please visit www1.deltadentalins.com/brand-new-day-medicare or call Delta Dental’s Customer Service Center at 844-282-7638 (TTY 711). A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Participating Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access Delta Dental’s automated information line at 844-282-7638 (TTY 711) during regular business hours to obtain information about Member’s eligibility and Benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write Delta Dental with your question(s), please mail your inquiry to the following address:

Delta Dental
1130 Sanctuary Parkway
Alpharetta, GA 30009

DEFINITIONS

Terms when capitalized in this Plan booklet have defined meanings, given in the section below or throughout the booklet sections.

Appeal -- is something you do if you disagree with a decision to deny a request for dental care services or payment for services you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a service, you think you should be able to receive.

Benefits -- the dental services under this Plan to which you are entitled to receive.

Calendar Year -- the 12 months of the year from January 1st through December 31st.

Claim Form -- the standard form used to file a claim or request a Pre-Treatment Estimate.

Contract -- the Agreement between BRAND NEW DAY Plan and Delta Dental of California for the Provision of Dental Services.

Contractholder -- BRAND NEW DAY Plan.

Cost-sharing -- the amounts which may be charged to a Member as the Member's share of the cost for the provision of covered services. Cost sharing under this Plan consists of copayments listed in Attachment A.

Delta Dental Participating Provider (Participating Provider) -- means a person licensed to practice dentistry when and where performed who has entered into a contract with Delta Dental agreeing to participate in this Plan and provide covered services in general dentistry to Members.

Emergency Service -- means dental care furnished to a Member needed to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Member to result in either: (i) placing the Member's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

Effective Date -- the original date the Plan starts. This date is given on this booklet's cover and Attachment A.

Member -- a person with Medicare who is eligible to get covered services, who has enrolled in the Plan and whose enrollment has been confirmed by CMS.

Non Participating Provider -- a dentist who has not entered into an agreement with Delta Dental to be a Participating Provider under this Plan.

Plan -- this dental plan which describes the Benefits, limitations, exclusions, terms and conditions of coverage for Members enrolled in Contractholder's Medicare Advantage Plan.

Plan Year -- the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

Pre-Treatment Estimate -- an estimation of the allowable Benefits under the Plan for the services proposed.

Procedure Code -- the Current Dental Terminology® (CDT) number assigned to a Single Procedure by the American Dental Association.

Reasonable means that a Member exercises prudent judgment in determining that a dental emergency exists and makes at least one attempt to contact his/her Participating Provider to obtain Emergency Services and, in the event the Participating Provider is not available, makes at least one attempt to contact Delta Dental for assistance before seeking care from another Participating Provider.

Single Procedure -- a dental procedure that is assigned a separate Procedure Code.

Specialist Services -- mean services performed by a licensed dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized in writing by Delta Dental.

Treatment in Progress -- means any single dental procedure, as defined by the Procedure Code that has been started while the Member was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Member continues to be eligible for Benefits under the Plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established, full or partial dentures for which an impression has been taken.

How to use this Plan - Choice of Participating Provider

To receive Benefits under this Plan, you must select a Participating Provider from the directory of Participating Providers. If you fail to select a Participating Provider or the Participating Provider selected by you becomes unavailable, we will request you select another Participating Provider, or we will assign you to a Participating Provider. You may change your assigned Participating Provider by directing a request to the Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711). In order to ensure that your Participating Provider is notified, and our eligibility lists are correct, changes in Participating Providers must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a membership packet that tells you the effective date of your Plan and the address and telephone number of your Participating Provider. After the effective date in your membership packet, you may obtain dental services under the Plan. To make an appointment simply call your Participating Provider's facility and identify yourself as a Member through BRAND NEW DAY Plan. Inquiries regarding availability of appointments and accessibility of Participating Providers should be directed to the Customer Service department at 844-282-7638 (TTY users 711).

EACH MEMBER MUST GO TO HIS OR HER ASSIGNED PARTICIPATING PROVIDER TO OBTAIN COVERED SERVICES, EXCEPT EMERGENCY SERVICES OR SERVICES PROVIDED BY A SPECIALIST, WHICH MUST BE PREAUTHORIZED IN WRITING BY DELTA DENTAL. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PLAN.

If your assigned Participating Provider's agreement with Delta Dental terminates, that Participating Provider will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Continuity of Care

Existing Members:

You may have the right to have completion of care with your terminated Participating Provider for certain specified dental conditions. Please call Customer Service at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Participating Provider. We are not required to continue your care with that Participating Provider if you are not eligible for coverage under the Plan or if we cannot reach agreement with your terminated Participating Provider on the terms regarding your care.

New Members:

You may have the right to the qualified benefit of completion of care with a Non Participating Provider for certain specified dental conditions. Please call the Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Non Participating Provider. We are not required to continue your care with that dentist if you are not eligible under the Plan or if we cannot reach agreement with your dentist on the terms regarding your care.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711).

Benefits, Limitations and Exclusions

This Plan provides the Benefits described in Attachment A, Description of Benefits and Copayments subject to the limitations and exclusions described in Attachment B. The services are performed as deemed appropriate by your attending Participating Provider. A Participating Provider may provide services either personally or through associated dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the Attachment A, Description of Benefits and Copayments directly to the Participating Provider or Specialist who provides treatment. Charges for broken appointments (unless notice is received by the dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the Description of Benefits and Copayments.

Emergency Services

If Emergency Services are needed, you should contact your Participating Provider whenever possible. If you are a new Member needing Emergency Services, but do not have an assigned Participating Provider yet, contact Delta Dental's Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) for help in locating a Participating Provider. Benefits for Emergency Services by a Non Participating Provider are limited to necessary care to stabilize your condition and/or provide palliative relief when you:

- 1) have made a Reasonable attempt to contact the Participating Provider and the Participating Provider is unavailable or you cannot be seen within 24 hours of making contact; or
- 2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Services, or it is Reasonable for you to access Emergency Services without prior contact with Delta Dental; or
- 3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Participating Provider to receive Emergency Services.

Benefits for Emergency Services not provided by the Participating Provider are limited to a maximum of \$100.00 per emergency less the applicable Copayment. If the maximum is exceeded, or the above conditions are not met, you are responsible for any charges for services by a dentist other than your Participating Provider.

Specialist Services

Specialist Services must be referred by the assigned Participating Provider and preauthorized in writing by Delta Dental. All preauthorized Specialist Services will be paid by us less any applicable Copayments.

Second Opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Participating Provider. Delta Dental may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) or write to Delta Dental.

Second opinions will be provided at another Participating Provider's facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by a Non Participating Provider if an appropriately qualified Participating Provider is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file an Appeal with BRAND NEW DAY. Please refer to the section of this booklet titled "Grievance and Appeals Process" below for an explanation of how to file an Appeal.

Claims for Reimbursement

Claims for Emergency Services or preauthorized Specialist Services should be submitted to Delta Dental within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is Claims Department, P. O. Box 1810, Alpharetta, GA 30023.

Provider Compensation

A Participating Provider is compensated by Delta Dental through monthly capitation (an amount based on the number of Members assigned to the Participating Provider), and by Members through required Cost Sharing for treatment received. A Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Copayment paid by the Member. In no event does Delta Dental pay a Participating Provider or a Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

In the event we fail to pay a Participating Provider, you will not be liable to that Participating Provider for any sums owed by us. The Participating Provider's contract with Delta Dental contains a provision prohibiting the Participating Provider from charging a Member for any sums owed by Delta Dental. Except for the provisions in Emergency Services, if you have not received Preauthorization for treatment from a Non Participating Provider or Specialist, and we fail to pay that dentist you may be liable to that dentist for the cost of services.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number listed in this booklet.

Processing Policies

The dental care guidelines for the Plan explain to Participating Providers what services are covered under the dental Contract. Participating Providers will use their professional judgment to determine which services are appropriate for the Member. Services performed by the Participating Provider that fall under the scope of Benefits of the dental Plan are provided subject to any Copayments. If a Participating Provider believes that a Member should obtain treatment from a Specialist, the Participating Provider contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a Specialist. A Member may contact Delta Dental's Customer Service department at 844-282-7638 Monday through Sunday from 8 a.m. to 8 p.m., 7 days a week (TTY users call 711) for information regarding the dental care guidelines for the Plan.

Coordination of Benefits

This Plan provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits Plan if the other policy or Plan covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Plan by Specialists or Non Participating Providers are coordinated with such other group dental insurance policy or any group dental benefits Plan. The determination of which policy or Plan is primary shall be governed by the rules stated in the Contract.

If this plan is secondary, it will pay the lesser of:

- the amount that it would have paid in the absence of any other dental benefit coverage, or
- the enrollee's total out-of-pocket cost payable under the primary dental benefit plan.

A Member must provide to Delta Dental and Delta Dental may release to or obtain from any insurance company or other organization, any information about the Member that

is needed to administer coordination of benefits. Delta Dental shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Plan. Delta Dental will have the right to recover from a dentist, Member, insurance company or other organization, as Delta Dental chooses, the amount of any Benefits paid by Delta Dental which exceeds its obligations under these coordination of benefit provisions.

Grievance and Appeals Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Participating Providers to the courtesy extended you by our telephone representatives. If you have any question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Participating Provider, you have the right to file a grievance or appeal with BRAND NEW DAY. See your BRAND NEW DAY Evidence of Coverage Booklet for information on the grievance process or contact BRAND NEW DAY at the 866-255-4795 on your BRAND NEW DAY Plan Member ID card.

Renewal and Termination of Benefits

This Plan renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and BRAND NEW DAY does not accept the change. All Benefits terminate for any Member as of the date that this Plan is terminated, such person ceases to be eligible under the terms of this Plan, or such person's enrollment is cancelled under the terms of this Plan. We are not obligated to continue to provide Benefits to any such person in such event, except for completion of Single Procedures commenced while this Plan was in effect.

Cancellation of Enrollment

To be eligible for Benefits under this Plan, you must be enrolled under one of the various Medicare Advantage health plans or products offered by BRAND NEW DAY. If you lose your eligibility or you terminate your enrollment under your BRAND NEW DAY plan you are not eligible to receive Benefits under this Plan. See your BRAND NEW DAY Evidence of Coverage Booklet for enrollment terms and conditions.

SCHEDULE A

Description of Benefits and Copayments

DHMO - CAC39 - Enhanced Mandatory Option 2

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to Schedule B for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DHMO program and is not to be interpreted as Current Dental Terminology (“CDT”), CDT-2023 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association (“ADA”). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report - <i>1 per 6 month period</i>	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post operative visit) - <i>1 per 6 month period</i>	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient - <i>1 per 6 month period</i>	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 series every 2 years</i>	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost

D0272	Bitewings two radiographic images - <i>limited to 1 every 12 months, per provider</i>	No Cost
D0273	Bitewings three radiographic images - <i>limited to 1 every 12 months, per provider</i>	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 2 series per year, per provider</i>	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 12 months</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i>	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	No Cost
D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis cleaning - adult - <i>Limited to 2 per year</i>	No Cost
D1206	Topical application of fluoride varnish	No Cost
D1208	Topical application of fluoride - excluding varnish	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to first and second permanent molars</i>	\$10.00
D1353	Sealant repair - per tooth - <i>limited to first and second permanent molars</i>	\$10.00
D1354	Application of caries arresting medicament - per tooth - 1 per 6 month period	\$12.00
D1510	Space maintainer - fixed - unilateral - per quadrant	\$75.00
D1516	Space maintainer - fixed - bilateral, maxillary	\$95.00
D1517	Space maintainer - fixed - bilateral, mandibular	\$95.00

D1520	Space maintainer - removable - unilateral - per quadrant	\$75.00
D1526	Space maintainer - removable - bilateral, maxillary	\$95.00
D1527	Space maintainer - removable - bilateral, mandibular	\$95.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	\$20.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	\$20.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	\$20.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

- Fillings are limited to one amalgam, resin composite filling per surface per tooth, every 2 calendar years.

- Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #3 for additional information.

- Base metal is the benefit. If a crown, pontic, inlay, onlay or indirectly fabricated post and core is made of noble or high noble metal, an additional fee up to \$250.00 per tooth will be charged for the upgrade. This charge also applies to a titanium crown.

- Porcelain and other tooth-colored materials (i.e. resin) on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$250.00.

D2140	Amalgam - one surface, primary or permanent	\$40.00
D2150	Amalgam - two surfaces, primary or permanent	\$50.00
D2160	Amalgam - three surfaces, primary or permanent	\$60.00
D2161	Amalgam - four or more surfaces, primary or permanent	\$70.00
D2330	Resin-based composite - one surface, anterior	\$60.00
D2331	Resin-based composite - two surfaces, anterior	\$70.00
D2332	Resin-based composite - three surfaces, anterior	\$80.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$90.00

D2390	Resin-based composite crown, anterior	\$98.00
D2391	Resin-based composite - one surface, posterior	\$90.00
D2392	Resin-based composite - two surfaces, posterior	\$100.00
D2393	Resin-based composite - three surfaces, posterior	\$110.00
D2394	Resin-based composite - four or more surfaces, posterior	\$120.00
D2510	Inlay - metallic - one surface	\$300.00
D2520	Inlay - metallic - two surfaces	\$300.00
D2530	Inlay - metallic - three or more surfaces	\$300.00
D2542	Onlay - metallic - two surfaces	\$400.00
D2543	Onlay - metallic - three surfaces	\$400.00
D2544	Onlay - metallic - four or more surfaces	\$400.00
D2610	Inlay - porcelain/ceramic - one surface	\$400.00
D2620	Inlay - porcelain/ceramic - two surfaces	\$400.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	\$400.00
D2642	Onlay - porcelain/ceramic - two surfaces	\$400.00
D2643	Onlay - porcelain/ceramic - three surfaces	\$400.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	\$400.00
D2650	Inlay - resin-based composite - one surface	\$400.00
D2651	Inlay - resin-based composite - two surfaces	\$400.00
D2652	Inlay - resin-based composite - three or more surfaces	\$400.00
D2662	Onlay - resin-based composite - two surfaces	\$400.00
D2663	Onlay - resin-based composite - three surfaces	\$400.00
D2664	Onlay - resin-based composite - four or more surfaces	\$400.00
D2710	Crown - resin-based composite (indirect) - limited to permanent anterior teeth	\$200.00
D2712	Crown - 3/4 resin-based composite (indirect)	\$200.00
D2720	Crown - resin with high noble metal	\$200.00
D2721	Crown - resin with predominantly base metal	\$200.00
D2722	Crown - resin with noble metal	\$200.00
D2740	Crown - porcelain/ceramic	\$400.00
D2750	Crown - porcelain fused to high noble metal	\$350.00
D2751	Crown - porcelain fused to predominantly base metal	\$275.00
D2752	Crown - porcelain fused to noble metal	\$400.00

D2780	Crown - 3/4 cast high noble metal	\$400.00
D2781	Crown - 3/4 cast predominantly base metal	\$400.00
D2782	Crown - 3/4 cast noble metal	\$400.00
D2783	Crown - 3/4 porcelain/ceramic	\$400.00
D2790	Crown - full cast high noble metal	\$400.00
D2791	Crown - full cast predominantly base metal	\$400.00
D2792	Crown - full cast noble metal	\$400.00
D2794	Crown - titanium and titanium alloys	\$400.00
D2799	Interim crown - further treatment or completion of diagnosis necessary prior to final impression	\$25.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$50.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$50.00
D2920	Re-cement or re-bond crown	\$50.00
D2921	Reattachment of tooth fragment, incisal edge or cusp (anterior)	\$98.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth	\$190.00
D2930	Prefabricated stainless steel crown - primary tooth	\$150.00
D2931	Prefabricated stainless steel crown - permanent tooth - <i>1 in 36 months</i>	\$170.00
D2932	Prefabricated resin crown - anterior primary tooth - <i>1 in 36 months</i>	\$170.00
D2933	Prefabricated stainless steel crown with resin window - <i>1 in 36 months</i>	\$190.00
D2940	Protective restoration	\$40.00
D2941	Interim therapeutic restoration - primary dentition	\$40.00
D2949	Restorative foundation for an indirect restoration	\$150.00
D2950	Core buildup, including any pins when required	\$150.00
D2951	Pin retention - per tooth, in addition to restoration	\$50.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	\$220.00
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	\$110.00
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	\$160.00

D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$90.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	\$50.00
D2975	Coping	\$110.00
D2980	Crown repair necessitated by restorative material failure	\$25.00
D2981	Inlay repair necessitated by restorative material failure	\$25.00
D2982	Onlay repair necessitated by restorative material failure	\$25.00
D2983	Veneer repair necessitated by restorative material failure	\$25.00
D2990	Resin infiltration of incipient smooth surface lesions	\$65.00

D3000-D3999 IV. ENDODONTICS

- Endodontic services are limited to 1 per tooth, per lifetime (i.e. root canal).

D3110	Pulp cap - direct (excluding final restoration)	\$25.00
D3120	Pulp cap - indirect (excluding final restoration)	\$40.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$150.00
D3221	Pulpal debridement, primary and permanent teeth	\$150.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$180.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$300.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration)	\$380.00
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration)	\$490.00
D3330	<i>Root canal</i> - endodontic therapy, molar tooth (excluding final restoration)	\$620.00
D3331	Treatment of root canal obstruction; non-surgical access	\$180.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$200.00
D3333	Internal root repair of perforation defects	\$160.00
D3346	Retreatment of previous root canal therapy - anterior	\$500.00
D3347	Retreatment of previous root canal therapy - premolar	\$620.00
D3348	Retreatment of previous root canal therapy - molar	\$720.00

D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$190.00
D3352	Apexification/recalcification - interim medication replacement	\$130.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$150.00
D3410	Apicoectomy - anterior	\$420.00
D3421	Apicoectomy - premolar (first root)	\$460.00
D3425	Apicoectomy - molar (first root)	\$480.00
D3426	Apicoectomy (each additional root)	\$150.00
D3427	Periradicular surgery without apicoectomy	\$360.00
D3430	Retrograde filling - per root	\$130.00
D3450	Root amputation - per root	\$220.00
D3920	Hemisection (including any root removal), not including root canal therapy	\$190.00
D3921	Decoronation or submergence of an erupted tooth	\$80.00

D4000-D4999 V. PERIODONTICS

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

- No more than 2 quadrants of periodontal scaling and root planing per appointment/per day are allowable.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant - once per quadrant in 36 months	\$220.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant - once per quadrant in 36 months	\$150.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth - once per quadrant in 36 months	\$150.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$540.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$540.00
D4245	Apically positioned flap	\$425.00
D4249	Clinical crown lengthening - hard tissue	\$500.00

D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant - <i>once per quadrant in 36 months</i>	\$780.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant - <i>once per quadrant in 36 months</i>	\$550.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	\$360.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	\$300.00
D4270	Pedicle soft tissue graft procedure	\$400.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	\$320.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	\$480.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	\$480.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 1 per quadrant per year</i>	\$60.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 1 per quadrant per year</i>	\$35.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110 or D4346 per 6 month period</i>	\$15.00
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i>	\$40.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - <i>included as part of other covered periodontal procedures</i>	\$40.00
D4910	Periodontal maintenance - limited to 1 treatment per 6 month period	\$40.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes other delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 2 per denture per calendar year.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	\$450.00
D5120	Complete denture - mandibular	\$450.00
D5130	Immediate denture - maxillary	\$600.00
D5140	Immediate denture - mandibular	\$600.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$500.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$500.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$600.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$600.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$350.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$350.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$600.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$600.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery	\$600.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	\$600.00

D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5511	Repair broken complete denture base, mandibular	\$100.00
D5512	Repair broken complete denture base, maxillary	\$100.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$80.00
D5611	Repair resin partial denture base, mandibular	\$120.00
D5612	Repair resin partial denture base, maxillary	\$120.00
D5621	Repair cast partial framework, mandibular	\$140.00
D5622	Repair cast partial framework, maxillary	\$140.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	\$140.00
D5640	Replace broken teeth - per tooth	\$100.00
D5650	Add tooth to existing partial denture	\$100.00
D5660	Add clasp to existing partial denture - per tooth	\$120.00
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
D5710	Rebase complete maxillary denture	\$200.00
D5711	Rebase complete mandibular denture	\$200.00
D5720	Rebase maxillary partial denture	\$200.00
D5721	Rebase mandibular partial denture	\$200.00
D5730	Reline complete maxillary denture (chairside)	\$100.00
D5731	Reline complete mandibular denture (chairside)	\$100.00
D5740	Reline maxillary partial denture (chairside)	\$100.00
D5741	Reline mandibular partial denture (chairside)	\$100.00
D5750	Reline complete maxillary denture (laboratory)	\$200.00
D5751	Reline complete mandibular denture (laboratory)	\$200.00
D5760	Reline maxillary partial denture (laboratory)	\$200.00
D5761	Reline mandibular partial denture (laboratory)	\$200.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - <i>limited to 1 in any 12 consecutive months</i>	\$300.00

D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - <i>limited to 1 in any 12 consecutive months</i>	\$300.00
D5850	Tissue conditioning, maxillary	\$50.00
D5851	Tissue conditioning, mandibular	\$50.00
D5863	Overdenture - complete maxillary	\$450.00
D5864	Overdenture - partial maxillary	\$450.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES

All services associated with implants are listed at the actual member co-payment amount. No additional fee is allowable for porcelain, noble metal, high noble metal or titanium for procedures associated with implants.

D6010	Surgical placement of implant body: endosteal implant	\$1,023.00
D6011	Second stage implant surgery	\$247.00
D6012	Surgical placement of interim implant body	\$726.00
D6013	Surgical placement of mini implant	\$665.00
D6040	Surgical placement: eposteal implant	\$2,160.00
D6050	Surgical placement: transosteal implant	\$2,051.00
D6055	Connecting bar - implant supported or abutment supported	\$250.00
D6056	Prefabricated abutment - includes modification and placement	\$418.00
D6057	Custom abutment	\$486.00
D6058	Abutment supported porcelain/ceramic crown	\$1,110.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	\$1,096.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	\$350.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	\$1,056.00
D6062	Abutment supported cast metal crown (high noble metal)	\$1,003.00
D6063	Abutment supported cast metal crown (predominantly base metal)	\$861.00
D6064	Abutment supported cast metal crown (noble metal)	\$912.00
D6065	Implant supported porcelain/ceramic crown	\$1,040.00
D6066	Implant supported crown - porcelain fused to high noble alloys	\$1,013.00

D6067	Implant supported crown - high noble alloys	\$984.00
D6068	Abutment supported retainer for porcelain/ceramic FPD	\$1,110.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	\$1,096.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	\$1,035.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	\$1,056.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	\$1,028.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	\$930.00
D6074	Abutment supported retainer for cast metal FPD (noble metal)	\$1,005.00
D6075	Implant supported retainer for ceramic FPD	\$1,092.00
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	\$1,064.00
D6077	Implant supported retainer for metal FPD - high noble alloys	\$984.00
D6082	Implant supported crown - porcelain fused to predominantly base alloys	\$350.00
D6090	Repair implant prosthesis	\$127.00
D6091	Replacement of replaceable part	\$136.00
D6092	Re-cement or re-bond implant/abutment supported crown	\$45.00
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	\$65.00
D6094	Abutment supported crown - titanium and titanium alloys	\$670.00
D6096	Remove broken implant retaining screw	\$45.00
D6101	Debridement of a peri-implant defect	\$263.00
D6102	Debride/osseous contour of peri-implant defect	\$47.00
D6103	Bone graft for repair of peri-implant defect	\$263.00
D6194	Abutment supported retainer crown, FPD - titanium and titanium alloys	\$400.00
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	\$60.00

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

- Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #3 for additional information.

- Base metal is the benefit. If a crown, pontic, inlay, onlay or indirectly fabricated post and core is made of noble or high noble metal, an additional fee up to \$250.00 per tooth will be charged for the upgrade. This charge also applies to a titanium crown.

- Porcelain and other tooth-colored materials (i.e. resin) on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$250.00.

D6210	Pontic - cast high noble metal	\$400.00
D6211	Pontic - cast predominantly base metal	\$400.00
D6212	Pontic - cast noble metal	\$400.00
D6240	Pontic - porcelain fused to high noble metal	\$400.00
D6241	Pontic - porcelain fused to predominantly base metal	\$400.00
D6242	Pontic - porcelain fused to noble metal	\$400.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	\$400.00
D6245	Pontic - porcelain/ceramic	\$400.00
D6250	Pontic - resin with high noble metal	\$200.00
D6251	Pontic - resin with predominantly base metal	\$200.00
D6252	Pontic - resin with noble metal	\$200.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	\$400.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	\$400.00
D6602	Retainer inlay - cast high noble metal, two surfaces	\$375.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$375.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$350.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	\$350.00
D6606	Retainer inlay - cast noble metal, two surfaces	\$360.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$360.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	\$400.00

D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	\$400.00
D6610	Retainer onlay - cast high noble metal, two surfaces	\$375.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	\$375.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$350.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	\$350.00
D6614	Retainer onlay - cast noble metal, two surfaces	\$360.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$360.00
D6720	Retainer crown - resin with high noble metal	\$200.00
D6721	Retainer crown - resin with predominantly base metal	\$200.00
D6722	Retainer crown - resin with noble metal	\$200.00
D6740	Retainer crown - porcelain/ceramic	\$400.00
D6750	Retainer crown - porcelain fused to high noble metal	\$400.00
D6751	Retainer crown - porcelain fused to predominantly base metal	\$400.00
D6752	Retainer crown - porcelain fused to noble metal	\$400.00
D6780	Retainer crown - 3/4 cast high noble metal	\$400.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$400.00
D6782	Retainer crown - 3/4 cast noble metal	\$400.00
D6790	Retainer crown - full cast high noble metal	\$400.00
D6791	Retainer crown - full cast predominantly base metal	\$400.00
D6792	Retainer crown - full cast noble metal	\$400.00
D6930	Re-cement or re-bond fixed partial denture	\$60.00
D6940	Stress breaker	\$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	\$25.00
D6999	Unspecified fixed prosthodontic procedure, by report	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$40.00

D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$100.00
D7220	Removal of impacted tooth - soft tissue	\$210.00
D7230	Removal of impacted tooth - partially bony	\$290.00
D7240	Removal of impacted tooth - completely bony	\$360.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$350.00
D7250	Removal of residual tooth roots (cutting procedure)	\$210.00
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	\$350.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$340.00
D7280	Exposure of an unerupted tooth	\$210.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$290.00
D7283	Placement of device to facilitate eruption of impacted tooth	\$250.00
D7286	Incisional biopsy of oral tissue - soft - does not include pathology laboratory procedures	\$260.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$150.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$150.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$170.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$170.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$380.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$380.00
D7471	Removal of lateral exostosis (maxilla or mandible)	\$330.00
D7472	Removal of torus palatinus	\$330.00
D7473	Removal of torus mandibularis	\$330.00
D7509	Marsupialization of odontogenic cyst	\$380.00
D7510	Incision and drainage of abscess - intraoral soft tissue	\$40.00
D7960	Frenulectomy - also known as Frenectomy or Frenotomy - separate procedure not incidental to another procedure	\$180.00

D7970	Excision of hyperplastic tissue - per arch	\$170.00
D7971	<i>Excision of pericoronal gingiva</i>	\$120.00
D8000-D8999	XI. ORTHODONTICS - Not Covered	
D9000-D9999	XII. ADJUNCTIVE GENERAL	
D9110	<i>Palliative treatment of dental pain - per visit</i>	\$20.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia - <i>1 per 6 month period</i>	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	\$75.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	\$75.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	\$75.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	\$75.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$40.00
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	\$50.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary - <i>1 per 6 month period</i>	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular - <i>1 per 6 month period</i>	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary - <i>1 per 6 month period</i>	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular - <i>1 per 6 month period</i>	No Cost
D9943	Occlusal guard adjustment	\$10.00
D9944	Occlusal guard - hard appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$300.00

D9945	Occlusal guard - soft appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$300.00
D9946	Occlusal guard - hard appliance, partial arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$300.00
D9950	Occlusion analysis - mounted case	\$160.00
D9951	Occlusal adjustment - limited - for natural teeth only	\$70.00
D9952	Occlusal adjustment - complete - for permanent dentition	\$120.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	\$170.00
D9986	Missed appointment - <i>without 24 hour notice</i>	No Cost
D9987	Canceled appointment - without 24 hour notice	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review	No Cost

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.
2. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by an oral surgeon for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241);
3. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Contact the Customer Service department at 800-422-4234 if you have questions regarding the additional fee or name brand services.

Exclusions of Benefits

1. Any procedure that is not specifically listed under Schedule A, Description of Benefits and Copayments.
2. Any procedure that in the professional opinion of the Contract Dentist:
 - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
 - b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant, unless listed as a covered benefit.
8. Consultations for non-covered benefits.
9. Dental services received from any dental facility other than the assigned Contract Dentist or a preauthorized dental specialist except for Emergency Services as described in the Contract and/or Evidence of Coverage.
10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, Home Health services or other similar care facility.
11. Ambulance services.
12. Durable Medical Equipment.
13. Mental health services.
14. Chemical Dependency services.
15. Prescription drugs.
16. General anesthesia and/or intravenous sedation/analgesia.
17. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DHMO Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Note

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