



**KAISER PERMANENTE®**

Kaiser Permanente Insurance Company

Dear Insured:

Thank you for choosing Kaiser Permanente Insurance Company's (KPIC) Dental Assistance Insurance Plan.

Enclosed is your new Certificate of Insurance (COI) and Table of Allowances. It supersedes and replaces any Certificate of Insurance and Table of Allowances that KPIC may have previously issued to you for this coverage. Please note that this new COI now reflects the name of the new Dental Trust, UMB Bank.

KPIC's Administrator for the Dental Assistance Insurance Plan is Delta Dental of California. For questions, please call the following phone numbers:

**Questions Regarding**

**Phone Number**

Claims or Benefits

(888) 335-8227

Eligibility, Enrollment or cost

(800) 464-4000

A list of participating dentists in your area

(800) 4-AREA-DR or visit Delta Dental's website at [www.deltadentalca.org](http://www.deltadentalca.org).

You may also write to Delta Dental at:

Delta Dental of California  
P.O. Box 997330  
Sacramento, CA 95899-7330

Thank you for being a part of the Kaiser Permanente Health Care Program.

Sincerely,

**Kaiser Permanente Insurance Company**

P.O. Box 24223, Oakland, CA 94623-1223

**KAISER PERMANENTE INSURANCE COMPANY**

One Kaiser Plaza  
Oakland, California 94612

**GROUP DENTAL CERTIFICATE**

This is your Certificate of Insurance (hereinafter Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Group Policy (hereinafter Policy). The Policy is issued to the UMB Bank (the Trust), issued in the state of Missouri. The Trust Administrator is Kaiser Permanente Insurance Company (KPIC). The Policy is available for inspection by the Covered Person during normal business hours at KPIC's Home Office.

This Certificate is not an insurance policy. The complete terms of the coverage are set forth in the Group Policy. Benefit payment is governed by all the terms, conditions and limitations of the Group Policy. If the Group Policy and this Certificate differ, the Group Policy will govern. The Group Policy and the Certificate are governed by the laws of the state in which the Group Policy was delivered. The Group Policy may be amended at any time without Your consent or prior notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

This Certificate was issued on the basis that the information on Your enrollment form was correct and complete. If any information on the enrollment form was not correct or complete, write to KPIC's Administrator within ten days of receipt of this Certificate. An error or omission may result in loss of coverage as of Your Effective Date. You may contact the Administrator at the following address:

Delta Dental of California  
P.O. Box 997330  
Sacramento, CA 94105

This Certificate supersedes and replaces any and all certificates that may have been previously issued to You for the coverage described herein.

In this Certificate, Kaiser Permanente Insurance Company will be referred to as: "KPIC", "we", "us", or "our". The Covered Person will be referred to as: "You" or "Your".

This Certificate is important to You and Your family. Please read this Certificate carefully and keep it in a safe place.

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## INTRODUCTION

### How To Use This Certificate

This Certificate includes a Table of Allowances that lists Your Covered Dental Services. However, it is very important that You read Your entire Certificate.

This Certificate uses many terms that have very specific definitions for the purpose of this plan. These terms are capitalized so that You can easily recognize them, and are defined in the General Definitions section. Other parts of this Certificate may contain definitions specific to those provisions. Terms that are used only within one section may be defined only in those sections. Please read these definitions carefully.

### Introduction To Your Plan

Please read the following information carefully. It will help You understand how the provider You select can affect the dollar amount You must pay.

KPIC pays for Covered Dental Services that are received from any licensed Dentist. But your out-of-pocket costs under the Group Policy may be lower for Covered Dental Services received from a Participating Dentist than those received from Non-participating Dentists.

KPIC is not responsible for Your decision to receive treatment or services from a Participating or Non-Participating Dentist. Nor is KPIC liable for the qualifications of providers or treatments or services provided.

For a directory of Delta's Dentists, please contact our Administrator, Delta Dental of California (Delta Dental), at 1-800-765-6003 or visit Delta Dental's web site at: [www.deltadentalca.org](http://www.deltadentalca.org).

### Who Can Answer Your Questions?

For assistance with questions regarding Your coverage, such as Your benefits, Your current eligibility status, or name and address changes, please have your ID card available when You call our Administrator:

Delta Dental of California  
Customer Services Department  
1(800)-765-6003

Or You may write to:

Delta Dental of California  
P.O. Box 997330  
Sacramento. CA 94105

Or You may contact Delta Dental on the Internet at:

[www.deltadentalca.org](http://www.deltadentalca.org)

### IMPORTANT NOTICE

If You require this Certificate of Insurance or any other document issued to You in connection with this dental insurance coverage printed in another language other than English, please call 1(800)-765-6003. Translated documents and language interpretation may be available. Please note that not all foreign languages are available for translation.

## GENERAL DEFINITIONS

The following terms have special meaning throughout this Certificate. Other parts of this Certificate may contain definitions specific to those provisions. Terms that are used only within one section of the Certificate are defined in those sections.

**Administrator** means Delta Dental of California (Delta Dental), P.O. Box 997330, Sacramento, CA 94105. KPIC reserves the right to change the Administrator at any time during the term of the Group Policy without prior written notice.

**Calendar Year** means a period of time: 1) beginning at 12:01 a.m. on January 1<sup>st</sup> of any year; and 2) terminating at midnight on December 31<sup>st</sup> of that same year.

**Calendar Year Benefit Maximum** means the total maximum benefit payable for Covered Dental Services incurred in a Calendar Year. Please refer to the Table of Allowances section of the Certificate for the Calendar Year Benefit Maximum applicable to Your plan.

### **Categories of Benefits means:**

*Diagnostic Services* are the necessary procedures to assist the Dentist in evaluating Your dental health and to determine necessary treatments.

*Preventive Services* are the necessary procedures and techniques to prevent the occurrence of dental abnormalities or diseases.

*Basic Services* are the necessary procedures to restore the teeth (other than crowns or cast restorations), oral surgery, endodontic (root canals) and periodontic (gum) procedures.

*Crowns and cast restorations* are caps, veneers, inlays and onlays.

*Prosthodontic Services* are procedures involving bridges and dentures to replace missing teeth.

**Covered Dental Services** means those dental services which a Covered Person is entitled to receive pursuant to the Group Policy and are defined and listed under the General Benefits section of the Certificate. Please refer to the Table of Allowances section of the Certificate for the list of Covered Dental Services and their corresponding maximum allowance payable.

**Covered Person** means a person covered under the terms of the Group Policy and who is duly enrolled as a Federal Employee under the trust agreement.

**Deductible** means the amount You must pay for dental care each Calendar Year, while insured under the Group Policy, before any benefits are payable during the Calendar Year. The Deductible will apply to each Covered Person separately, and must be met within each Calendar Year, subject to the maximum Deductible specified in the Certificate of Insurance. Please refer to the Table of Allowances for the Deductible amount applicable to Your plan.

**Dentist** means a duly licensed dentist acting within the scope of his or her license at the time the treatment or service is performed in the state in which the services are provided.

**Dependent** means only: a) Your spouse or Domestic Partner; and b) Your or Your spouse's unmarried child who is of an age within the age limits for Dependent children shown in the Eligibility, Effective Date and Termination Date section of the COI, and who chiefly depends on You for support or is named in a Qualified Medical Child Support Order. The word "**child**" includes: a) Your step-child; b) the child of Your son or daughter if Your son or daughter is an insured Dependent under the Group Policy; and c) any other child who lives with You and for whom You are the legal guardian. A child shall be deemed to be a Dependent of not more than one person.

**Effective Date** means the date coverage under the Policy starts.

## GENERAL DEFINITIONS

**Eligible Person** means the Federal Employee and Eligible Dependents set forth under the ELIGIBILITY section of this Certificate, and persons ceasing to meet such conditions who elect continued coverage as provided under the CONTINUED COVERAGE OPTION section of this Certificate.

**Explanation of Benefits (EOB)** means a summary of covered expenses KPIC or its Administrator will send to You after Your Dentist files a claim.

**Federal Employee** means a Covered Person duly enrolled in the KFHP medical plan for Federal Employees. Federal Employees shall include retired Federal Employees enrolled in Kaiser Foundation Health Plan's Medical Plan for Federal Employees.

**Fee Actually Charged** means the fee for a particular dental service or procedure which a Dentist submits to Delta on a claim, less any portion of such fee which is discounted, waived, or rebated, or which the Dentist does not use good faith efforts to collect.

**Health Plan** means Kaiser Foundation Health Plan, Inc (KFHP).

**Non-Participating Dentist** means a licensed Dentist who does not have filed fees/negotiated fees on file with its Administrator.

**Participating Dentist** means a licensed Dentist who has a signed agreement with KPIC or its Administrator and has agreed to the filed fees/negotiated fees applicable to Participating Dentists under this dental insurance plan. The Participating Dentist agrees to charge the Covered Person under this Plan these filed fees/negotiated fees.

**Policyholder** means the employer or trust or other entity noted on the Group Policy as the Policyholder who conforms to the administrative and other provisions established under the Group Policy.

**Predetermination** means a pre-treatment estimate KPIC or its Administrator makes upon request of Your Dentist, detailing what the plan will pay for a proposed treatment, and what Your responsibility will be.

**Premiums** means the money paid to KPIC each month for Your and Your Dependent's dental coverage.

**Single Procedure** means a dental procedure to which a separate Procedure Number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).

**Table of Allowances (Allowance)** means a schedule that lists the dental procedures and their maximum corresponding Allowance that may be paid for each Covered Dental Service. Delta Dental shall pay the lesser of the Dentist's Usual, Customary and Reasonable fee, the Fee Actually Charged, or the Allowance. Any difference between the Allowance and the Dentist's fee may be the responsibility of the patient.

**Trust** means the arrangement between KPIC, the Trust Administrator, and UMB Bank, the Trustee. The Group Policy is issued to the Trust.

**Trust Administrator** means KPIC, One Kaiser Plaza, Oakland, CA 94612.

### **Usual, Customary and Reasonable (UCR):**

A **USUAL** fee is the amount which an individual dentist regularly charges and receives for a given

## GENERAL DEFINITIONS

service or the fee actually charged, whichever is less.

A **CUSTOMARY** fee is within the range of Usual fees charged and received for a particular service by dentists of similar training in the same geographic area.

A **REASONABLE** fee can be Usual and Customary, or KPIC or its Administrator may agree that a fee that falls above Customary is justified by a superior level or complexity (difficulty) of treatment than that customarily provided.

**Waiting Period** means the period of time, as stated in the Table of Allowances, that must be satisfied before benefits are payable. Please refer to the Table of Allowances at the end of this Certificate for the specific Covered Dental Services that are subject to a Waiting Period.

## ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

You must be an Eligible Person to become insured under the Group Policy.

### Eligibility for Insurance

Federal Employees are eligible to enroll in this plan on the first day of the month coinciding with their enrollment under Kaiser Foundation Health Plan's Medical Plan(s) for Federal Employees. Federal Employees shall include retired Federal Employees enrolled in Kaiser Foundation Health Plan's Medical Plan for Federal Employees.

Federal Employees shall have the option to enroll for coverage under the Policy under the following conditions:

- a. Federal Employees and their covered Dependents may enroll only when first eligible or during an open enrollment period to be held not more than once annually.
- b. If both spouses qualify as a Federal Employee, one spouse may enroll as a Dependent of the other spouse, but Dependent children may enroll for coverage under only one Federal Employee.
- c. Federal Employees shall agree to pay the monthly Premium.
- d. Federal Employees who enroll agree to remain enrolled for a minimum of twelve (12) consecutive months. Federal Employees who discontinue coverage shall not be allowed to re-enroll until the next open enrollment period.
- e. Once a Federal Employee elects to discontinue Dependent coverage, Dependents may not be re-enrolled under the Policy until the next annual open enrollment period, unless the Dependent is the subject of a Qualified Medical Child Support Order requiring the Federal Employee to provide the Dependent Benefits under the Policy.

Eligible Dependents are the Federal Employee's spouse or domestic partner and unmarried Dependent children from birth to age 22. Children include step-children, adopted children, children placed for adoption and foster children, provided they depend upon the Federal Employee for support and maintenance. The Dependents of Federal Employees become Eligible Dependents on the same date that the Federal Employee, of whom they are a Dependent, becomes eligible for coverage under the Policy. Later-acquired Dependents become Eligible Dependents as soon as they acquire Dependent status.

An unmarried child, 22 years or older, may continue to be an Eligible Dependent and coverage will continue even though not enrolled as a full-time student if they are incapable of self-sustaining employment by reason of mental or physical handicap and if they are chiefly dependent upon the Federal Employee for support and maintenance. Proof of such handicap or incapacity and dependency must be submitted at least thirty-one (31) days prior to the Dependent child attaining the limiting age of 22 years, and subsequently as may be required by KPIC or its Administrator. Neither KPIC nor its Administrator will request such proof more frequently than annually after the child in question has reached age 26.

Dependents in military service are not eligible.

Every Federal Employee and his/her respective Dependents meeting the preceding conditions of eligibility are eligible for coverage under the Policy. However, KPIC or its Administrator will not provide Benefits for any Federal Employee or his/her respective Dependents unless: (1) Federal Employee enrolls when first eligible or during an open enrollment period; and (2) the appropriate monthly Premium payment is made as required by this Certificate, for the months in which KPIC provides coverage for Covered Dental Services.

A Dependent's eligibility ends along with the Federal Employee's eligibility, or sooner if the Dependent loses his or her dependent status, unless continued coverage is chosen in a timely fashion by or on behalf of the Dependent(s) under the CONTINUED COVERAGE OPTION section of this Certificate. Eligibility for such continued coverage will continue for the period required by the option. In any event, eligibility ends immediately when coverage under this Certificate or the Certificate under which this Certificate is issued ends.

## ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

### Enrolling in the Dental Plan

When You enroll for coverage under the Policy, You are enrolling for a period of one year. If You discontinue coverage before that year is up, You may not re-enroll until the next open enrollment period.

You and Your Dependent's enrollment under the Policy must parallel the enrollment in the Kaiser Foundation Health Plan's Medical Plan for Federal Employees. This means that if You enrolled Your Dependents as members under Kaiser Foundation Health Plan's Medical Plan, Your Dependents must be enrolled under this dental insurance plan.

### Termination of Your Dental Insurance

Your dental insurance will terminate on the earlier of the following dates:

1. The date the You cease to be covered under the KFHP Federal Employee Medical Plan;
2. The date You or Your representative commits an act of fraud or makes an intentional misrepresentation of a material fact;
3. The end of the grace period after the Covered Person fails to pay any required premium to KPIC or its Administrator when due or KPIC does not receive the premium payment in a timely fashion;  
or
4. The last day of the month in which You cease to qualify as a Covered Person.

If KPIC or its Administrator wants to change the Premium or Benefits, KPIC will give at least thirty (30) days advance written notice (In California, 45 days advance written notice will be given to the producer of the business, if any) of such changes to the Insured. Such an advance notice will have the effect of a notice of termination as of the end of period for which Premiums have been paid, unless the Insured agrees to the new provisions.

If the Insured notifies KPIC or its Administrator in writing of his/her intention to terminate coverage under the Policy as of any date other than the end of the Contract Term, such notice will be treated as a failure to pay Premium, and such notice will constitute a waiver of the notification and billing required of KPIC or its Administrator under this Certificate.

If the Insured believes that the Policy or coverage hereunder, has been terminated or not renewed due to their dental/health status or requirements for Covered Dental Services, they may request a review by the Commissioner of the Department of Insurance of the state in which this Certificate was issued.

If the Policy is terminated for any cause, KPIC or its Administrator is not required to predetermine services beyond the termination date or to pay for services provided after such termination date, except for the completion of Single Procedures that began while this Certificate was in effect which are otherwise Covered Dental Services under the Policy.

Within 30 days after the end of the Policy, KPIC or its Administrator will return to the Insured any Premium paid which are applicable to a time period after the termination date, together with amounts due on claims, if any, less any amounts due to KPIC or its Administrator.

If KPIC accepts the proper amount of Premium, after termination of this Certificate and without requiring a new application, that acceptance will reinstate this Certificate as though it never terminated, unless KPIC or its Administrator, within five (5) business days after it receives such payment, either: (1) refunds the payment so made; or (2) issues a new Certificate accompanied by written notice stating clearly those respects in which the new certificate differs from the terminated Certificate in Benefits, coverage, or otherwise.

## PRE-DETERMINATIONS

After an examination, Your Dentist will talk to You about treatment You may need. The cost of treatment is something You may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than \$300, we encourage You to ask Your Dentist to request for a Pre-determination of Benefits.

A Predetermination of Benefits does not guarantee payment. It is an estimate of the amount KPIC will pay if You are eligible and meet all the requirements of the Group Policy at the time the treatment You have planned is completed.

In order to receive Pre-determination of Benefits, Your Dentist must send a statement of proposed treatment to our Administrator listing the proposed treatment. Our Administrator will send Your Dentist a Notice of Predetermination of Benefits which estimates how much of the treatment costs KPIC will pay and how much You will have to pay. After You review the estimate with Your Dentist and You decide to go ahead with the treatment plan, Your Dentist returns the statement to the following address for payment after treatment has been completed.

Delta Dental of California  
P.O. Box 997330  
Sacramento, CA 95899-7330

Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination of Benefit is issued if the patient is eligible. Payment will depend on the patient's eligibility and the remaining annual maximum when completed services are submitted to KPIC or to its Administrator.

Pre-determination of Benefits help prevent any misunderstanding about Your financial responsibilities.

## GENERAL BENEFITS

### MONTHLY RATES (PREMIUM) FOR 2005

Insured only	<b>On File</b>
Insured and one dependent	<b>On File</b>
Insured and two or more dependents	<b>On File</b>

### Payment of Monthly Charges

Kaiser Foundation Health Plan, Inc. will bill the rate with their monthly medical rate.

The dental coverage described herein is not in effect until KPIC or its Administrator receives the Initial Premium from the Federal Employee. The due date for subsequent Premium is the 10th day of each month. The Federal Employee agrees to pay subsequent Premium no later than 31 days following the Premium due date, unless the Federal Employee has given written notice requesting termination of dental coverage under the Policy in accordance with the Termination section of this Certificate. The Federal Employee will be responsible for the payment of pro rata Premium for the time dental coverage under the Policy was in force during the 31-day grace period.

At the end of this Certificate you will find a Table of Allowances which lists dental procedures and the maximum Allowance that KPIC will pay for Covered Dental Services. KPIC will pay the lesser of the Dentist's Usual, Customary and Reasonable fee, the Fee Actually Charged, or the Allowance.

During a typical dental office visit, You might receive several of the services listed in Your Table of Allowances.

After each claim is submitted, You will receive a statement from KPIC or its Administrator, explaining which services were provided, what KPIC will pay and the amount You are responsible for paying.

### Calendar Year Deductible

You pay the first \$50 of Table of Allowance expenses to meet Your per person Calendar Year Deductible, up to a Maximum of \$150 for Your family. There is no deductible on Diagnostic and Preventive services. Please refer to the Table of Allowances for the Calendar Year Deductible amount applicable to Your plan.

### Calendar Year Maximum

Your benefits cover a Maximum of \$1,000 of Covered Dental Services for each covered enrollee per Calendar Year. Please refer to the Table of Allowances for the Calendar Year Maximum amount applicable to Your plan.

### Waiting Periods

Some of the Covered Dental Services listed in the Table of Allowances are subject to a Waiting Period. This is the period of time that You and Your covered Dependents are required to have satisfied before a specific dental service will be a covered benefit. Please refer to the Table of Allowances for the specific Covered Dental Services that are subject to a Waiting Period.

### Choosing Your Dentist

Although You may choose any Dentist, You get special advantages when You go to Participating Dentists. These dentists have agreed to handle all Your claims paperwork for You, and to charge only fees that have been approved by KPIC or its Administrator. KPIC reimburses Participating Dentists directly, so You are responsible only for the allowed amount not covered by the Table of Allowances.

## GENERAL BENEFITS

If You go to a non-Participating Dentist, You are responsible for the entire bill and must submit a claim to KPIC's Administrator for reimbursement of covered dental procedures. KPIC's Administrator will reimburse You directly in accordance with the Table of Allowances.

For a complete list of Participating Dentists in Your area, call toll-free 1(800)-765-6003, or visit Delta Dental's web site at [www.deltadentalca.org](http://www.deltadentalca.org).

Written notice of the occurrence or commencement of Covered Dental Services, treatment and supplies must be provided to KPIC or its Administrator within 20 days after such loss, or as soon as is reasonably possible. Written proof of such loss must be proved to KPIC or its Administrator within 90 days after such loss. Failure to provide such proof shall neither invalidate nor reduce any claim if it is not reasonably possible to furnish such proof within such time, provided such proof is provided as soon as is reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. If a claim is denied due to a Participating Dentist's failure to make a timely submission, You shall not be liable to that dentist for the amount which would have been payable by KPIC, provided that You advised the dentist of Your eligibility at the time of treatment.

### Insuring Clause

Your dental program covers several categories of Benefits, when the services are provided by a licensed Dentist, and when they are necessary and customary under the generally accepted standards of dental practice. After You have satisfied any Deductible requirements, KPIC will pay the lesser of the Dentist's Usual, Customary, and Reasonable fee, the fee Actually Charged, or the Allowance. Any difference between the Allowance and the Dentist's fee may be the responsibility of the patient. If the Dentist discounts, waives, or rebates any portion of Your or Your Dependent's co-insurance amount, KPIC only provides as benefits the applicable allowances reduced by the amount that such fees, or Allowances are discounted, waived or rebated.

### Covered Dental Services and Limitations

#### I. Diagnostic and Preventive Benefits

##### Diagnostic:

- oral examinations
- x-rays
- diagnostic casts
- biopsy/tissue examinations
- emergency palliative treatment
- specialist consultations

##### Preventive:

- prophylaxis treatments (cleanings)
- fluoride treatments
- space maintainers

#### Limitations on Diagnostic and Preventive Benefits:

- A. An oral examination shall not be covered more than twice in any calendar year while the patient is an Insured under any of KPIC's dental insurance plans.
- B. Prophylaxis treatments (cleanings) are limited under *General Limitations*.
- C. Full mouth x-rays are covered only after five (5) years have elapsed following any prior provision of full mouth x-rays under any of KPIC's dental insurance plans. Bitewing x-rays are covered on request by the dentist, but not more than once every (6) months for children under

## GENERAL BENEFITS

age 18, and once in a calendar year for adults age 18 and over, while the patient is insured under any of KPIC's dental insurance plans.

### II. Basic Benefits

Oral surgery:	Extractions and certain other surgical procedures, including pre- and post-operative care
Restorative:	Amalgam, synthetic porcelain and plastic restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
Endodontic:	Treatment of the tooth pulp (root canal treatments)
Periodontic:	Treatment of gums and bones supporting the teeth
Sealants:	Protective coating for posterior molar (back) teeth

#### Limitations on Basic Benefits:

- A. Periodontal procedures which include prophylaxis (cleaning) are limited under *General Limitations*.
- B. Sealants are available for first molars for eligible person under age 9 and for second molars for Eligible Persons under age 15. The benefit includes the application of sealants only to permanent posterior (back) molar teeth with no caries (decay), with no restorations and with the occlusal (chewing) surface intact. The sealants benefit does not include the repair or replacement of a sealant on any tooth within two years of its application.

### III. Crowns, Inlays, Onlays and Cast Restoration Benefits

Crowns, inlays, onlays and cast restorations will be covered when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.

#### Limitation on Crowns, Inlays, Onlays and Cast Restoration Benefits:

Crowns, inlays, onlays and cast restorations will be replaced only after five (5) years have elapsed following any prior provision under any of KPIC's dental insurance plans.

### IV. Prosthodontic Benefits

Procedures for construction or repair of fixed bridges, partial or complete dentures.

#### Limitations on Prosthodontic Benefits:

*Prosthodontic treatment is subject to a six-month waiting period. See Table of Allowances for further reference.*

- A. Prosthodontic appliances, including but not limited to fixed bridges and partial or complete dentures, will be replaced only after five (5) years have elapsed following any prior provision of such appliances under any of KPIC's dental insurance plans, except when KPIC determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement will be made of a prosthodontic appliance not provided under any of KPIC's dental insurance plans if it is unsatisfactory and cannot be made satisfactory.
- B. KPIC will pay the listed allowance toward the dentist's fee for a standard cast chrome or acrylic partial denture or a standard complete denture. (A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.)

## GENERAL BENEFITS

- C. Implants (materials implanted into or on bone or soft tissue), or the removal of implants, are not benefits under the Policy. However, if implants are provided in connection with a covered prosthetic appliance, KPIC will allow the cost of a standard complete or partial denture toward the cost of implants and the prosthetic appliances. If KPIC makes an allowance toward the cost of such procedures, KPIC will not pay for any replacement placed within five years thereafter.

### V. General Limitations—Prophylaxis Treatments and Optional Services

- A. Benefits under the Policy shall include only the first two prophylaxis treatments (cleanings) or Single Procedures which include prophylaxis, or combination thereof, provided to a patient in any calendar year period while he or she is an Eligible Person under any of KPIC's dental insurance plans.
- B. If an Eligible Person selects a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedures, KPIC will pay the listed allowance for the lesser procedure, and the patient is responsible for the remainder of the dentist's fee (examples: a crown where a silver filling would restore the tooth or a precision denture where a standard denture would suffice).

### VI. Services Not Covered (Exclusions)

- A. Services for injuries or conditions which are compensable under Workers' Compensation or Employers' Liability Laws; services which are provided by any federal or state government agency or are provided without cost to the insured person by any municipality, county or other political subdivision, except as may be required under state law.
- B. Services with respect to congenital (hereditary) or development (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- C. Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting.
- D. Prosthodontic services or any Single Procedure started prior to the date the person became eligible for such services under the Policy.
- E. Prescribed or applied therapeutic drugs, premedication or analgesia.
- F. Experimental procedures.
- G. All hospital costs and any additional fees charged by the dentist for hospital treatment.
- H. Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services.
- I. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues) or implants (materials implanted into or on bone or soft tissue) or the removal of implants, except as provided under *Limitations on Prosthodontic Benefits*.
- J. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues, unless covered by a rider to the Policy.

## GENERAL BENEFITS

- K. Orthodontic services.
- L. Procedures not shown on the Table of Allowances..

## GENERAL EXCLUSIONS AND LIMITATIONS

Unless specifically stated otherwise in the Group Policy, in your Schedule of Coverage or elsewhere in this Certificate, no payment will be made for any treatment or service in connection with the following:

1. Any treatment or procedure not listed as Covered Dental Services under the General Benefits section.
2. Charges in excess of the Usual, Customary and Reasonable fee, the Fee Actually Charged, or the amounts listed on the Table of Allowances.
3. Services for injuries covered by Workers' Compensation or Employer's Liability Laws.
4. Services which are provided to the Covered Person by any Federal or State Governmental Agency or are provided without cost to the Covered Person by any municipality, county or other political subdivision, except Medi-Cal benefits.
5. Services for cosmetic purposes 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.
6. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such treatment are equilibration and periodontal splinting.
7. Any Single Procedure, bridge, denture or other prosthodontic service which was started before the Enrollee was covered by this program.
8. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.
9. Experimental procedures.
10. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
11. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.
12. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").
13. Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants.
14. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues.
15. Replacement of existing restoration for any purpose other than active tooth decay.
16. Intravenous sedation, occlusal guards and complete occlusal adjustment.
17. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program.
18. Hypnosis.
19. Crowns, Inlays, Onlays and Cast Restoration.
20. Prosthodontic Services.
21. Charges for completion of forms.
22. Charges for speech therapy.
23. Charges for lost or stolen appliances.
24. Services for which no charge is normally made in the absence of insurance.
25. Plaque Control programs, oral hygiene, and dietary instructions.
26. Orthodontic treatment except for eligible Dependent children under Plan E with orthodontics.
27. Treatment plans that are more expensive than those customarily provided or specialized techniques used instead of standard procedures; for example, a precision denture where a standard denture would suffice.
28. Pit and fissure sealants, unless for the first molars of children up to age 9 and second molars for children up to age 14. The molar must have no decay and no restoration, and the occlusal surface must be intact. Coverage does not include the repair or replacement of a sealant on any tooth within 3 years of application.

## GENERAL PROVISIONS

### **Time Effective**

The effective time for any dates used is 12:01 AM at the address of the Policyholder.

### **Incontestability**

Any statement made by the Policyholder or a Covered Person in applying for insurance under the Group Policy will be considered a representation and not a warranty. No statement made by any person shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or the insured's beneficiary. After the Group Policy has been in force for 2 years, its validity cannot be contested except for nonpayment of premiums or fraudulent misstatement as determined by a court of competent jurisdiction. After a Covered Person's insurance has been in force for 2 years during his or her lifetime, its validity cannot be contested due to misstatement other than a fraudulent misstatement. Only statements that are in writing and signed by the Covered Person can be used in a contest.

### **Legal Actions**

No action at law or in equity may be brought to recover under the Group Policy prior to the expiration of 60 days after the claim has been filed as required by the Group Policy. Also, no action may be brought unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Group Policy.

### **Misstatement of Age**

If the age of any person insured under the Group Policy has been misstated: (1) premiums shall be adjusted to correspond to his or her true age; and (2) if benefits are affected by a change in age, benefits will be corrected accordingly (in which case the premium adjustment will take the correction into account).

### **Examination**

When reasonably necessary, KPIC, at its own expense, may require an examination of the person for whom a claim is made.

### **Money Payable**

All sums payable by or to KPIC or its Administrator must be paid in the lawful currency of the United States.

## COORDINATION OF BENEFITS

### Coordination of Benefits

This coordination of benefits (COB) provision applies to this plan when an insured or the insureds covered Dependent has health care coverage under more than one (1) plan. "Plan" and "this plan" are defined herein.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

- a) Shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but
- b) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. This reduction is described under the provision entitled "Effect on the Benefits of This Plan" as set forth in this section.

### Definitions

- A. **Plan** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
  1. Group insurance, group subscriber contracts, uninsured arrangements of group or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
  2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Plans, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is a separate plan.
- B. **This plan** is the part of the Trust Policy that provides benefits for dental care expenses.
- C. **Primary plan/secondary plan.** The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two (2) plans covering the person, this plan may be a primary plan as to one (1) or more other plans and may be a secondary plan as to a different plan(s).
- D. **Allowable expense** means a necessary, reasonable and customary item of expense when the item of expense is covered at least in part by one (1) or more plans covering the person for whom the claim is made. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of that reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.
- E. **Claim determination period** means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this COB provision or similar provision takes effect.

## COORDINATION OF BENEFITS

### Order of Benefit Determination Rules

- A. General.** When there is a basis for a claim under this plan and another plan. This plan is a secondary plan which has its benefits determined after those of the other plan, unless:
1. The other plan has rules coordinating its benefits with those of this plan; and
  2. Both those rules and this plan's rules require that this plan's benefits be determined before those of the other plan.
- B. Rules.** This plan determines its order of benefits using the first of the following rules which applies:
1. Nondependent/dependent. The benefits of the plan which covers the person as an employee, member or Insured (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that -- if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    - a. Secondary to the plan covering the person as a Dependent; and
    - b. Primary to the plan covering the person as other than a Dependent (for example, a retired employee), then the benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.
  2. Dependent child/parents not separated or divorced. Except as stated, when this plan and another plan cover the same child as a Dependent of different persons, called parents:
    - a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
    - b. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described previously and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
  3. Dependent child/separated or divorced. If two (2) or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - a. First, the plan of the parent with custody of the child;
    - b. Then, the plan of the spouse of the parent with the custody of the child; and
    - c. Finally, the plan of the parent not having custody of the child;
    - d. If the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge; or
    - e. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the **Order Of Benefit Determination**

## COORDINATION OF BENEFITS

### Rules.

4. Active/inactive employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.
5. Continuation of coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
  - a. First, the benefits of a plan covering the person as an employee, member or Insured (or as that person's Dependent); and
  - b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described here and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered an employee, member or Insured longer are determined before those of the plan which covered that person for the shorter term.

### Effect On The Benefits Of This Plan

**When This Section Applies:** This section applies when, in accordance with **Order Of Benefit Determination Rules**, this plan is a secondary plan as to one (1) or more other plans. In that event the benefits of this plan may be reduced under this section.

**Reduction in this plan's benefits:** The benefits of this plan will be reduced when the sum of:

1. The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and
2. The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses. When the benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

### Right To Receive And Release Needed Information

Certain facts are needed to apply these COB rules. KPIC has the right to decide which facts it needs. It may get needed facts from, or give them to, any other organization or person. KPIC need not tell or get the consent of any person to do this. Each person claiming benefits under this plan must give KPIC any facts it needs to pay the claim.

### Right to Receive and Release Information

Certain facts are needed to coordinate benefits. KPIC or its Administrator has the right to decide which facts it needs. KPIC or its Administrator may get needed facts from or give them to any other organization or person. KPIC or its Administrator need not tell, or get the consent of any person to do

## COORDINATION OF BENEFITS

this. Each person claiming benefits under this Plan must give KPIC or its Administrator any facts it needs to pay the claim.

### **Facility of Payment**

A payment made under another Plan may have included an amount which should have been paid under this Plan. If it does, KPIC or its Administrator may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. KPIC or its Administrator will not pay that amount again. The term **payment made** includes providing benefits in the form of services. In this case **payment made** means the reasonable cash value of the benefits provided in the form of services.

### **Right of Recovery**

If the amount of the payments made by KPIC or its Administrator is more than it should have paid, KPIC or its Administrator may recover the excess, within twelve months of the payment, from one or more of the following:

1. the persons KPIC or its Administrator has paid or for whom it has paid.
2. insurance companies.
3. other organizations.

The **amount of payments made** includes the reasonable cash value of any benefits provided in the form of services.

## CLAIMS AND APPEALS PROCEDURES

Benefits, unless otherwise provided in this Certificate, are available from the Eligibility Date of the Eligible Person.

An Eligible Person may choose the services of any licensed Dentist, but neither KPIC nor its Administrator guarantees the availability of any particular Dentist.

Before KPIC is obligated to approve and/or satisfy any claims under the Policy, KPIC or its Administrator is entitled to receive, to such extent as is lawful, such information and records relating to attendance to, or examination of, or treatment provided to an Eligible Person from any attending or examining dentist or from hospitals in which a dentist's care is provided, as may be required in the administration of such claims; or to require that an Eligible Person be examined by a dental consultant retained by and paid for by KPIC or its Administrator in or near his or her community or residence. KPIC and its Administrator agree in every case to hold such information and records as confidential.

KPIC or KPIC's Administrator will pay a Participating Dentist directly for Covered Dental Services provided by that dentist. **CONTRACTS BETWEEN KPIC OR KPIC'S ADMINISTRATOR AND ITS PARTICIPATING DENTISTS PROVIDE THAT, IN THE EVENT KPIC OR KPIC'S ADMINISTRATOR FAILS TO PAY THE DENTIST, THE INSURED WILL NOT OWE THE DENTIST FOR ANY SUMS OWED BY KPIC OR KPIC'S ADMINISTRATOR.**

KPIC will pay the Insured directly for services provided by a dentist who is not a Participating Dentist, and those payments are not assignable.

Written notice of the occurrence or commencement of Covered Dental Services, treatment and supplies must be provided to KPIC within 20 days after such loss, or as soon as is reasonably possible. Written proof of such loss must be provided to KPIC within 90 days after such loss. Failure to provide such proof shall neither invalidate nor reduce any claim if it is not reasonably possible to furnish such proof within such time, provided such proof is provided as soon as is reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. If a claim is denied because a Participating Dentist failed to make timely submission, the Insured does not owe that dentist the amount which would have been payable by KPIC, provided that the Insured advised the dentist of his or her eligibility for Benefits at the time of treatment.

KPIC will give each Participating Dentist, and any other dentist or Eligible Person, not later than 15 days after such request, a standard form to make a claim for payment for services covered by this Certificate. In order to make a claim for payment, such form (completed by the dentist who provided the services and by the Eligible Person or the patient's parent or guardian if such patient is a minor) must be submitted to KPIC's Administrator at the address on the form. If KPIC fails to provide a claim form within 15 days after such request, the person making such claim will be deemed to have complied with the requirements of this Certificate as to proof of loss upon submitting, within the time fixed above, written proof covering the occurrence, character and extent of the loss for which claim is made.

Benefits payable under the Policy shall be paid within 30 days of receipt of written proof of loss. No action in law or in equity shall be brought on the Policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Policy, and no such action shall be brought at all unless brought within three years from the expiration of time within which proof of loss is required under the Policy.

KPIC agrees to notify the Insured if any services submitted on a claim under the preceding paragraph are denied coverage as Benefits, in whole or in part, stating the reason(s) for the denial. Within sixty (60) days after receipt of such notice, the Insured may make a written request for review of such denial. Such request for review must be addressed to KPIC's Administrator, PO Box 997330, Sacramento, California 95899-7330, Telephone (888) 335-8227, Attention: Benefit Services

## CLAIMS AND APPEALS PROCEDURES

Department. Such request for review must state the reason(s) why the Insured believes that the denial of the claim was in error and must request any pertinent documents which they wish to review. The Benefit Services Department of KPIC's Administrator will make a full and fair review of the claim. KPIC's Administrator agrees to provide a decision on a request for review to the Insured in writing within 120 days after KPIC's Administrator receives the request for review.

The Benefits which KPIC provides are limited to the applicable percentages of Dentist's fees or Allowances specified in this Certificate. KPIC requires the Covered Person to pay the balance of any such fee or allowance, known as the "Patient Copayment," as a method of sharing the costs of providing dental Benefits between KPIC and the Insured. If the dentist discounts, waives or rebates any portion of the Patient Copayment to the Insured, KPIC only provides as Benefits the applicable Allowances reduced by the amount that such fees or Allowances are discounted, waived or rebated.

## CONTINUATION OF COVERAGE

You or Your Dependents may be entitled to continue coverage under this plan, at your expense, under applicable federal (COBRA) or state law (Cal-COBRA), when coverage terminates under the provisions of the Policy. Continued coverage will be: (A) available only to those Covered Persons who qualify at the time a qualifying event occurs; and (B) subject to the terms and conditions of the Policy.

A child that is born to or placed with an Insured Employee during a period of COBRA or Cal-COBRA coverage is eligible for coverage as a Dependent provided proper written notice and election takes place.

### **Continuation of Coverage under Federal Law (COBRA) (If applicable to the Group Policy)**

To continue Your coverage under the federal law (COBRA), you must elect to continue it simultaneously with Your Health Plan or KPIC medical coverage.

For an explanation of continuation of coverage under federal law, please refer to the Health Plan Evidence of Coverage. Please ask Your Group benefits administrator for the details about COBRA continuation coverage, such as how to elect coverage and how much You must pay Your Group.

### **Continuation of Coverage under State Law (Cal-COBRA) (If applicable to the Group Policy)**

Continuation of Coverage under State Law (Cal-COBRA) only applies to small employer groups with 2-19 eligible employees who are subject to California COBRA and who are not offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Federal COBRA).

A Covered Person may have a right to have this coverage continued under the Policy pursuant to Cal-COBRA when coverage terminates under the provisions of the Policy. Continued coverage will be available only to those Covered Persons who qualify at the time a qualifying event occurs and subject to the terms and conditions of the Policy.

For an explanation of continuation of coverage under state law, please refer to the Health Plan Evidence of Coverage. Please ask Your Group benefits administrator for the details about Cal-COBRA continuation coverage, such as how to elect coverage and how much You must pay Your Group.

### **Continued Coverage Option**

For purposes of this option, the following are "Qualifying Events":

- a. Death of the Insured.
- b. Divorce or legal separation from the Insured.
- c. The Insured becoming entitled to Medicare benefits.
- d. A dependent child ceasing to meet the description of dependent child.
- e. A Federal Chapter 11 bankruptcy proceeding which (within one year before or one year after the filing) causes a substantial elimination of coverage of the Insured or the Insured's Eligible Dependents.

Eligible Dependents whose coverage under this plan ends due to Qualifying Events a, b, c, or d, may choose to continue their coverage for thirty-six (36) months following the month in which the Qualifying Event occurs.

A Eligible Person whose coverage under this plan ends due to Qualifying Event e may choose to continue their coverage until death (in the case of an Eligible Person), or for thirty-six (36) months after the date of death of the Eligible Person (in the case of Eligible Dependents of a retired Eligible

## CONTINUATION OF COVERAGE

Employee).

Continued coverage can be chosen only by notice to KPIC's Administrator which must be given no later than sixty (60) days after a termination of coverage by reason of a Qualifying Event, or within sixty (60) days after the Insured receives a notice from KPIC's Administrator about his or her rights to continued coverage because of the particular Qualifying Event, whichever is later. Persons for whom a Qualifying Event described in b or d occurs must report it to KPIC's Administrator within sixty (60) days, or lose their right to choose continued coverage.

Continued coverage chosen by a person under this Section is effective on the first day of the month following the applicable Qualifying Event described above. However, Benefits are not available to a person choosing continuing coverage until KPIC's Administrator receives the data about such person as required hereunder, along with all Premium then due for such person. KPIC's Administrator will not, in any event, make Benefits available hereunder with respect to any person for whom KPIC's Administrator does not receive such information and Premium within sixty (60) days after the date such person is required under this Option to notify KPIC's Administrator of his or her election.

Continued coverage will be the same as the coverage for similarly situated Insureds under this Certificate, and if coverage is modified for such Insureds, coverage for persons having continued coverage will be modified at the same time and in the same manner.

A person's continued coverage chosen under this Section will end on the last day of the month in which any of the following events first occurs:

- a. The period of continued coverage specified above ends.
- b. This Certificate ends.
- c. Insured fails to pay Premium for the person as required by this Certificate.
- d. The person with continued coverage becomes covered for dental Benefits under another group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such person covered under this plan.
- e. The person becomes eligible for Medicare benefits.

**TABLE OF ALLOWANCES**

**KPIC Dental Insurance Plan  
TABLE OF ALLOWANCES  
(Maximum Amount Payable For Covered Dental Services\*)**

<b>Calendar Year Benefit Maximum:</b>	\$1,000.00
<b>Calendar Year Deductibles:</b>	
Individual:	\$50.00
Family:	\$150.00

Code	Procedure	Allowance
<b>D0100-D0999 DIAGNOSTIC</b>		
<b>Clinical oral evaluations</b>		
D0120	Periodic oral evaluation .....	15.00
D0140	Limited oral evaluation – problem focused .....	21.00
D0150	Comprehensive oral evaluation – new or established patient .....	21.00
D0160	Detailed and extensive oral evaluation, problem focused .....	21.00
D0170	Reevaluation limited problem focused (established patient; not post operative visit) .....	21.00
D0180	Comprehensive periodontal evaluation – new or established patient .....	21.00
<b>Radiographs/diagnostic imaging (including interpretation)</b>		
D0210	Intraoral – complete series including bitewings .....	45.00
D0220	Intraoral periapical – first film .....	12.00
D0230	Intraoral periapical – each additional film .....	5.00
D0240	Intraoral – occlusal film .....	12.00
D0250	Extraoral – first film .....	19.00
D0260	Extraoral – each additional film .....	16.00
D0270	Bitewing – single film .....	11.00
D0272	Bitewings – two films .....	17.00
D0274	Bitewings – four films .....	24.00
D0277	Vertical bitewings – 7 to 8 films .....	45.00
D0290	Posterior – anterior or lateral skull and facial bone survey film .....	19.00
D0330	Panoramic film .....	37.00
D0340	Cephalometric film .....	33.00
<b>Oral pathology laboratory</b>		
D0472	Accession of tissue, gross exam, preparation and transmission of written report .....	59.00
D0473	Accession of tissue, gross & microscopic exam, preparation and transmission of written report .....	59.00
D0474	Accession of tissue, gross & micro exam, assessment of surgical margins for presence of disease, preparation and transmission of written report .....	59.00
<b>D1000-D1999 PREVENTIVE</b>		
<b>Dental prophylaxis</b>		
D1110	Prophylaxis – adult .....	36.00
D1120	Prophylaxis – child <i>through age 13</i> .....	28.00
<b>Topical fluoride treatment</b>		
D1201	Topical application of fluoride (including prophylaxis) – child <i>through age 13</i> .....	32.00
D1203	Topical application of fluoride (prophy not included) – child <i>through age 13</i> .....	11.00
D1204	Topical application of fluoride (prophy not included) – adult .....	9.00
D1205	Topical application of fluoride (including prophylaxis) – adult .....	38.00

\* The Table of Allowances lists the maximum amount that may be paid for each Covered Dental Service. The lesser of the Dentist's Usual, Customary and Reasonable Fee, the Fee Actually Charged, or the Allowance, will be paid. Any difference between the Allowance and the Dentist's fee may be the responsibility of the patient.

**TABLE OF ALLOWANCES**

<b>Code</b>	<b>Procedure</b>	<b>Allowance</b>
<b>Other preventive services</b>		
D1351	Sealant - per tooth .....	20.00
Space maintenance (passive appliances) ( <i>including all adjustments within six months following installation</i> ).		
D1510	Space maintainer – fixed – unilateral .....	115.00
D1515	Space maintainer – fixed – bilateral .....	191.00
D1520	Space maintainer – removable – unilateral .....	143.00
D1525	Space maintainer – removable – bilateral .....	187.00
<b>D2000-D2999 RESTORATIVE – Procedures subject to 6 month waiting period</b>		
<b>Amalgam restorations (including polishing)</b>		
D2140	Amalgam – one surface, primary or permanent .....	35.00
D2150	Amalgam – two surfaces, primary or permanent .....	43.00
D2160	Amalgam – three surfaces, primary or permanent .....	52.00
D2161	Amalgam – four or more surfaces, primary or permanent .....	58.00
<b>Resin – based composite restorations – direct</b>		
D2330	Resin-based composite – one surface, anterior .....	46.00
D2331	Resin-based composite – two surfaces, anterior .....	46.00
D2332	Resin-based composite – three surfaces, anterior .....	46.00
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior) .....	68.00
D2390	Resin-based composite crown, anterior .....	114.00
D2391	Resin-based composite – one surface, posterior .....	47.00
D2392	Resin-based composite – two surfaces, posterior .....	64.00
D2393	Resin-based composite – three surfaces, posterior .....	80.00
D2394	Resin-based composite – four or more surfaces, posterior .....	80.00
<b>Inlay/onlay restorations</b>		
D2510	Inlay – metallic – one surface .....	99.00
D2520	Inlay – metallic – two surfaces .....	133.00
D2530	Inlay – metallic – three or more surfaces .....	150.00
D2542	Onlay – metallic – two surfaces .....	191.00
D2543	Onlay – metallic – three surfaces .....	191.00
D2544	Onlay – metallic – four or more surfaces .....	191.00
D2650	Inlay – resin-based composite – one surface .....	34.00
D2651	Inlay – resin-based composite – two surfaces .....	50.00
D2652	Inlay – resin-based composite – three or more surfaces .....	63.00
<b>Crowns – single restoration only</b>		
D2710	Crown – resin (indirect) .....	80.00
D2712	Crown – ¾ resin-based composite (indirect) .....	80.00
D2720	Crown – resin with high noble metal .....	182.00
D2721	Crown – resin with predominantly base metal .....	163.00
D2722	Crown – resin with noble metal .....	177.00
D2740	Crown – porcelain/ceramic substrate .....	192.00
D2750	Crown – porcelain fused to high noble metal .....	182.00
D2751	Crown – porcelain fused to predominantly base metal .....	163.00
D2752	Crown – porcelain fused to noble metal .....	177.00
D2780	Crown – ¾ cast high noble metal .....	186.00

\* The Table of Allowances lists the maximum amount that may be paid for each Covered Dental Service. The lesser of the Dentist's Usual, Customary and Reasonable Fee, the Fee Actually Charged, or the Allowance, will be paid. Any difference between the Allowance and the Dentist's fee may be the responsibility of the patient.

**TABLE OF ALLOWANCES**

Code	Procedure	Allowance
<b>Crowns – single restoration only (continues)</b>		
D2781	Crown – ¾ cast predominantly base metal .....	186.00
D2782	Crown – ¾ cast noble metal .....	186.00
D2790	Crown – full cast high noble metal .....	183.00
D2791	Crown – full cast predominantly base metal .....	170.00
D2792	Crown – full cast noble metal .....	178.00
D2794	Crown – titanium .....	183.00
<b>Other restorative services</b>		
D2910	Re-cement inlay .....	27.00
D2915	Re-cement cast or prefabricated post and core .....	27.00
D2920	Re-cement crown .....	27.00
D2930	Prefabricated stainless steel crown – primary tooth .....	65.00
D2931	Prefabricated stainless steel crown – permanent tooth .....	74.00
D2932	Prefabricated resin crown .....	80.00
D2933	Prefabricated stainless steel crown with resin window .....	90.00
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth .....	90.00
D2950	Core buildup, including any pins .....	43.00
D2951	Pin Retention – per tooth, in addition to restoration .....	20.00
D2952	Cast post and core in addition to crown .....	92.00
D2954	Prefabricated post and core in addition to crown .....	75.00
D2960	Labial veneer (resin laminate) – chairside .....	116.00
D2961	Labial veneer (resin laminate) – laboratory .....	128.00
D2962	Labial veneer (porcelain laminate) – laboratory .....	161.00
D2980	Crown repair, by report .....	25.00
<b>D3000-D3999 ENDODONTICS – Procedures subject to 6 month waiting period</b>		
<b>Pulpotomy</b>		
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinoceamental junction and application of medicament .....	38.00
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) .....	38.00
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) .....	38.00
Procedures D3310 through D3450 include all test x-rays taken as part of the complete root canal procedure.		
<b>Endodontic therapy (including treatment plan, clinical procedures, and follow-up care).</b>		
D3310	Anterior (excluding final restoration) .....	193.00
D3320	Bicuspid (excluding final restoration) .....	227.00
D3330	Molar (excluding final restoration) .....	306.00
D3346	Re-treatment of previous root canal therapy – anterior .....	193.00
D3347	Re-treatment of previous root canal therapy – bicuspid .....	227.00
D3348	Re-treatment of previous root canal therapy – molar .....	306.00
D3351	Apexification/re-calcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) .....	56.00
D3352	Apexification/re-calcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) .....	56.00
D3353	Apexification/re-calcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.) .....	56.00

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**TABLE OF ALLOWANCES**

<b>Code</b>	<b>Procedure</b>	<b>Allowance</b>
<b>Apicoectomy/periradicular services</b>		
D3410	Apicoectomy/periradicular surgery – anterior .....	240.00
D3421	Apicoectomy/periradicular surgery – bicuspid (first root) .....	257.00
D3425	Apicoectomy/periradicular surgery – molar (first root) .....	294.00
D3426	Apicoectomy/periradicular surgery (each additional root) .....	50.00
D3430	Retrograde filling – per root .....	57.00
D3450	Root amputation – per root .....	166.00
<b>Other endodontic services</b>		
D3920	Hemisection (including any root removal), not including root canal therapy .....	121.00
<b>D4000-D4999 PERIODONTICS - Procedures subject to 6 month waiting period</b>		
<b>Surgical services</b> (including usual postoperative services).		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant .....	128.00
D4211	Gingivectomy or gingivoplasty – one to three teeth, per quadrant .....	77.00
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant .....	159.00
D4241	Gingival flap procedure, including root planing – one to three teeth, per quadrant .....	95.00
D4245	Apically positioned flap .....	159.00
D4249	Clinical crown lengthening – hard tissue .....	96.00
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant .....	342.00
D4261	Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant .....	205.00
D4263	Bone replacement graft – first site in quadrant .....	62.00
D4264	Bone replacement graft – each additional site in quadrant .....	47.00
D4266	Guided tissue regeneration – resorbable barrier, per site .....	135.00
D4267	Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal) ..	135.00
D4270	Pedicle soft tissue graft procedure .....	192.00
D4271	Free soft tissue graft procedure (including donor site surgery) .....	208.00
D4273	Subepithelial connective tissue graft procedures .....	233.00
<b>Non-surgical periodontal service</b>		
D4341	Periodontal scaling and root planing, per quadrant – four or more contiguous teeth or bounded teeth spaces, per quadrant .....	59.00
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant .....	35.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis .....	36.00
<b>Other periodontal services</b>		
D4910	Periodontal maintenance ( <i>following active therapy</i> ) .....	41.00
D4920	Unscheduled dressing change (by someone other than treating dentist) .....	36.00

**D5000-D5999 PROSTHODONTICS, REMOVABLE - Procedures subject to 12 month waiting period**

Procedures relating to dentures, partial dentures and relines include adjustments for a six month period following installation. Such procedures do not include specialized techniques involving precision dentures, personalization or characterizations.

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**TABLE OF ALLOWANCES**

Code	Procedure	Allowance
<b>Complete dentures</b> (including routine post-delivery care)		
D5110	Complete denture – maxillary .....	240.00
D5120	Complete denture – mandibular .....	241.00
D5130	Immediate denture – maxillary .....	240.00
D5140	Immediate denture – mandibular .....	241.00
<b>Partial dentures</b> (including routine post-delivery care)		
D5211	Maxillary partial denture – resin base (including conventional clasps, rests and teeth) .....	203.00
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth) ..	212.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including conventional clasps, rests and teeth) .....	287.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including conventional clasps, rests and teeth) .....	287.00
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth) .....	216.00
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth) .....	216.00
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth) .....	120.00
<b>Adjustments to dentures</b>		
D5410	Adjust complete denture – maxillary .....	13.00
D5411	Adjust complete denture – mandibular .....	13.00
D5421	Adjust partial denture – maxillary .....	14.00
D5422	Adjust partial denture – mandibular .....	14.00
<b>Repairs to complete dentures</b>		
D5510	Repair broken complete denture base .....	31.00
D5520	Replace missing or broken teeth – complete denture (each tooth) .....	25.00
<b>Repairs to partial dentures</b>		
D5610	Repair resin denture base .....	30.00
D5620	Repair cast framework .....	25.00
D5630	Repair or replace broken clasp .....	36.00
D5640	Replace broken teeth – per tooth .....	27.00
D5650	Add tooth to existing partial denture .....	31.00
D5660	Add clasp to existing partial denture .....	37.00
<b>Denture rebase procedures</b>		
D5710	Rebase complete maxillary denture .....	94.00
D5711	Rebase complete mandibular denture .....	93.00
D5720	Rebase maxillary partial denture .....	89.00
D5721	Rebase mandibular partial denture .....	91.00
<b>Denture reline procedures</b>		
D5730	Reline complete maxillary denture (chairside) .....	46.00
D5731	Reline complete mandibular denture (chairside) .....	45.00
D5740	Reline maxillary partial denture (chairside) .....	45.00
D5741	Reline mandibular partial denture (chairside) .....	47.00
D5750	Reline complete maxillary denture (laboratory) .....	70.00
D5751	Reline complete mandibular denture (laboratory) .....	70.00
D5760	Reline maxillary partial denture (laboratory) .....	71.00
D5761	Reline mandibular partial denture (laboratory) .....	71.00

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**TABLE OF ALLOWANCES**

<b>Code</b>	<b>Procedure</b>	<b>Allowance</b>
<b>Interim prosthesis</b>		
D5820	Interim partial denture (maxillary) .....	85.00
D5821	Interim partial denture (mandibular) .....	85.00
<b>Other removable prosthetic services</b>		
D5850	Tissue conditioning, maxillary .....	25.00
D5851	Tissue conditioning, mandibular .....	24.00
<b>D6200-D6999 PROSTHODONTICS, FIXED - Procedures subject to 6 month waiting period</b> (Each abutment and each pontic constitutes a unit in a fixed partial denture.)		
<b>Partial denture pontics</b>		
D6210	Pontic – cast high noble metal .....	171.00
D6211	Pontic – cast predominantly base metal .....	138.00
D6212	Pontic – cast noble metal .....	168.00
D6214	Pontic – titanium .....	171.00
D6240	Pontic – porcelain fused to high noble metal .....	176.00
D6241	Pontic – porcelain fused to predominantly base metal .....	155.00
D6242	Pontic – porcelain fused to noble metal .....	170.00
D6250	Pontic – resin with high noble metal .....	176.00
D6251	Pontic – resin with predominantly base metal .....	155.00
D6252	Pontic – resin with noble metal .....	170.00
<b>Fixed partial denture retainers – inlays/onlays</b>		
D6545	Retainer – cast metal for resin bonded fixed prosthesis .....	88.00
D6602	Inlay – cast high noble metal, two surfaces .....	121.00
D6603	Inlay – cast high noble metal, three or more surfaces .....	135.00
D6604	Inlay – cast predominantly base metal, two surfaces .....	121.00
D6605	Inlay – cast predominantly base metal, three or more surfaces .....	135.00
D6606	Inlay – cast noble metal, two surfaces .....	121.00
D6607	Inlay – cast noble metal, three or more surfaces .....	135.00
D6610	Onlay – cast high noble metal, two surfaces .....	288.00
D6611	Onlay – cast high noble metal, three or more surfaces .....	288.00
D6612	Onlay – cast predominantly base metal, two surfaces .....	288.00
D6613	Onlay – cast predominantly base metal, three or more surfaces .....	288.00
D6614	Onlay – cast noble metal, two surfaces .....	288.00
D6615	Onlay – cast noble metal, three or more surfaces .....	288.00
D6624	Inlay – titanium .....	135.00
D6634	Onlay – titanium .....	288.00
<b>Fixed partial denture retainers – crowns</b>		
D6720	Crown – resin with high noble metal .....	181.00
D6721	Crown – resin with predominantly base metal .....	161.00
D6722	Crown – resin with noble metal .....	175.00
D6750	Crown – porcelain fused to high noble metal .....	181.00
D6751	Crown – porcelain fused to predominantly base metal .....	161.00
D6752	Crown – porcelain fused to noble metal .....	175.00
D6780	Crown – ¾ cast high noble metal .....	181.00
D6781	Crown – ¾ cast predominantly base metal .....	181.00

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**TABLE OF ALLOWANCES**

Code	Procedure	Allowance
D6782	Crown – ¾ cast noble metal .....	181.00
D6790	Crown – full cast high noble metal .....	180.00
D6791	Crown – full cast predominantly base metal .....	159.00
D6792	Crown – full cast noble metal .....	175.00
D6794	Crown – titanium .....	180.00
<b>Other fixed partial denture services</b>		
D6930	Re-cement fixed partial denture .....	33.00
D6940	Stress breaker .....	38.00
D6970	Cast post and core in addition to fixed partial denture retainer .....	56.00
D6971	Cast post as part of fixed partial denture retainer .....	56.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer .....	44.00
D6973	Core buildup for retainer, including any pins .....	35.00
D6980	Fixed partial denture repair, by report .....	50.00
<b>D7000-D7999 ORAL AND MAXILLOFACIAL SURGERY - Procedures subject to 6 month waiting period</b>		
<b>Extractions</b> (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D7111	Coronal remnants – deciduous tooth .....	20.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) .....	39.00
<b>Surgical extractions</b> (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth .....	74.00
D7220	Removal of impacted tooth – soft tissue .....	90.00
D7230	Removal of impacted tooth – partially bony .....	117.00
D7240	Removal of impacted tooth – completely bony, with unusual surgical complications .....	134.00
D7250	Surgical removal of residual tooth roots (cutting procedure) .....	78.00
<b>Other surgical procedures</b>		
D7260	Oroantral fistula closure .....	225.00
D7261	Primary closure of a sinus perforation .....	225.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth .....	132.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization) .....	98.00
D7285	Biopsy of oral tissue – hard (bone, tooth) .....	136.00
D7286	Biopsy of oral tissue – soft (all others) .....	108.00
<b>Alveoloplasty – surgical preparation of ridge for dentures</b>		
D7310	Alveoloplasty in conjunction with extractions – per quadrant .....	59.00
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant .....	36.00
D7320	Alveoloplasty not in conjunction with extractions – per quadrant .....	96.00
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant .....	58.00
<b>Vestibuloplasty</b>		
D7340	Vestibuloplasty – ridge extension (secondary epithelialization) .....	82.00
D7350	Vestibuloplasty – ridge extension (including soft tissue graft, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) .....	218.00

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**TABLE OF ALLOWANCES**

<b>Code</b>	<b>Procedure</b>	<b>Allowance</b>
<b>Surgical excision of soft tissue lesions</b>		
D7411	Excision of benign lesion greater than 1.25 cm .....	240.00
D7465	Destruction of lesion(s) by physical or chemical method, by report .....	100.00
<b>Surgical excision of intra-osseous lesions</b>		
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm .....	110.00
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm .....	160.00
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm .....	131.00
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm .....	273.00
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm .....	128.00
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm .....	220.00
<b>Excision of bone tissue</b>		
D7471	Removal of lateral exostosis (maxilla or mandible) .....	162.00
D7472	Removal of torus palatinus .....	162.00
D7473	Removal of torus mandibularis .....	162.00
D7485	Surgical reduction of osseous tuberosity .....	162.00
D7490	Radical resection of mandible with bone graft .....	1,000.00
<b>Surgical incision</b>		
D7510	Incision and drainage of abscess – intraoral soft tissue .....	48.00
D7520	Incision and drainage of abscess – extraoral soft tissue .....	70.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue .....	59.00
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system .....	60.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone .....	85.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body .....	237.00
<b>Treatment of fractures – simple</b>		
D7610	Maxilla – open reduction (teeth immobilized, if present) .....	470.00
D7620	Maxilla – closed reduction (teeth immobilized, if present) .....	377.00
D7630	Mandible – open reduction (teeth immobilized, if present) .....	929.00
D7640	Mandible – closed reduction (teeth immobilized, if present) .....	890.00
D7650	Malar and/or zygomatic arch – open reduction .....	600.00
D7660	Malar and/or zygomatic arch – closed reduction .....	200.00
D7670	Alveolus – closed reduction, may include stabilization of teeth .....	190.00
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches .....	1,000.00
<b>Treatment of fractures – compound</b>		
D7710	Maxilla – open reduction .....	38.00
D7720	Maxilla – closed reduction .....	23.00
D7730	Mandible – open reduction .....	1,000.00
D7740	Mandible – closed reduction .....	748.00
D7750	Malar and/or zygomatic arch – open reduction .....	800.00
D7760	Malar and/or zygomatic arch – closed reduction .....	200.00
D7770	Alveolus – open reduction stabilization of teeth .....	300.00
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches .....	1,000.00
<b>Reduction of dislocation and management of other temporomandibular joint dysfunctions</b>		
D7810	Open reduction of dislocation .....	800.00
D7820	Closed reduction of dislocation .....	61.00
D7830	Manipulation under anesthesia .....	172.00

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**TABLE OF ALLOWANCES**

<b>Code</b>	<b>Procedure</b>	<b>Allowance</b>
<b>Repair of traumatic wounds</b>		
D7910	Suture of recent small wounds up to 5 cm .....	200.00
<b>Complicated suturing</b> (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)		
D7911	Complicated suture – up to 5 cm .....	400.00
D7912	Complicated suture – greater than 5 cm .....	600.00
<b>Other repair procedures</b>		
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure .....	115.00
D7970	Excision of hyperplastic tissue – per arch .....	88.00
D7971	Excision of pericoronal gingival .....	43.00
D7972	Surgical reduction of fibrous tuberosity .....	43.00
D7980	Sialolithotomy .....	233.00
D7981	Excision of salivary gland, by report .....	1,000.00
D7982	Sialodochoplasty .....	50.00
D7983	Closure of salivary fistula .....	20.00
<b>D9000-D9999 ADJUNCTIVE GENERAL SERVICES</b>		
<b>Unclassified treatment</b>		
D9110	Palliative (emergency) treatment of dental pain – minor procedure .....	41.00
<b>Anesthesia</b>		
D9220	Deep sedation/general anesthesia – first 30 minutes .....	100.00
D9221	Deep sedation/general anesthesia – each additional 15 minutes .....	36.00
<b>Professional consultation</b>		
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment) .....	43.00
<b>Professional visits</b>		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed ..	24.00
D9440	Office visit – after regularly scheduled hours .....	49.00
<b>Drugs</b>		
D9610	Therapeutic drug injection, by report .....	6.00
<b>Miscellaneous services</b>		
D9930	Treatment of complications (postsurgical) – unusual circumstances, by report .....	19.00
D9951	Occlusal adjustment – limited .....	32.00

**Note:** This Appendix represents codes and nomenclature excerpted from the version of Current Dental Terminology (CDT) in effect at the date of this Contract or amendment was issued. CDT coding and nomenclature are the copyright of the American Dental Association, and have been accepted as the standard for data transmission purposes under federal Administrative Simplification regulations. For the purposes of this Appendix, Delta’s administration of Benefits, Limitations and Exclusions under this Contract will at all times be based on the then-current version of CDT whether or not a revised Appendix B is provided. Notes in italic type have been added by Delta Dental for clarification

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