Schedule of Benefits

MEMORIAL HERMANN Health Plan Commercial Group Plans

Notes:

- Copayments (Copay) - The specific dollar amount a Member must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment may be collected directly from a Member by a Network Provider. The Copayment amount does not count towards the Deductible.
- Single Highest Copay applies when multiple services that are subject to individual Copayments are performed on the same day by the same Network Provider. Please check your Evidence of Coverage for details.
- The Evidence of Coverage does not provide coverage when you use an Out-of-Network Provider, except for an Emergency.
- Some benefits may require Preauthorization. Please check your Evidence of Coverage for details.
- Please read the entire Evidence of Coverage for other Covered Services, Benefits, Exclusions, & Limitations.
- Benefits are applied per Calendar Year.
- This Evidence of Coverage does not cover Acupuncture, Cosmetic Surgery, dental or routine eye care (adult), Infertility treatment, long term care, weight loss programs, or non- emergency care when traveling outside the United States.
- In-Network Benefits are paid based on the Negotiated Rate.
- The Emergency Room Service Copayment does not count toward satisfying the Deductible.

2026 Schedule of Benefits – Select Gold 1000 HMO		
Annual	**Network Provider**	**Out-of-Network Provider**
Individual Deductible:	$1,000	N/A
Family Deductible:	$3,000	N/A
Individual Out-of-Pocket Maximum:	$8,700	N/A
Family Out-of-Pocket Maximum:	$17,400	N/A
Individual Pediatric Dental Out-of-Pocket Maximum:	$350	N/A
Family Pediatric Dental Out-of-Pocket Maximum:	$700	N/A
Coinsurance:	30%	N/A
Payment Order:	Copayment applies first (if applicable), then Deductible, then Coinsurance (if applicable).Copayment counts toward Maximum Out-of-Pocket amount.	

Schedule of Benefits				
Common Medical Event	**Services You May Need**	**Network Provider**	**Out-of-Network Provider**	**Exclusions & Limitations and Other Important Information**
If you visit a health care Provider's office or clinic	Primary care visit to treat an Illness or Injury	$25 Copay/visit Deductible does not apply	Not covered	None

If you visit a health care Provider's office or clinic	Specialist visit	$50 Copay/visit Deductible does not apply	Not covered	None
	Preventive care/screening/ Immunizations	No charge Deductible does not apply	Not covered	For Children under the age of 6: required Immunizations are not subject to Deductible, Copayment, or Coinsurance requirements for Network Providers. You may have to pay for services that aren't preventive. Ask your Provider if the services needed are preventive. Then check what Your Plan will pay for.
If you have a test	Diagnostic tests – Blood work	30% Coinsurance Deductible applies first	Not covered	Professional/ interpretation service is included in diagnostic blood work and x-ray Cost Share. Preauthorization required for all genetic testing and complex imaging.
	Diagnostic tests - X-rays	30% Coinsurance Deductible applies first	Not covered	
	Imaging (CT/PET scans, MRIs)	30% Coinsurance Deductible applies first	Not covered	
If you need immediate medical attention	Emergency room services	$400 Copay/visit Deductible does not apply		Copayment waived if admitted.
	Emergency medical transportation	30% Coinsurance/trip Deductible applies first		None
	Urgent Care	$50 Copay/visit Deductible does not apply		None
If you have a Hospital stay	Facility fee (e.g., Hospital room)	30% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Physician/surgeon fees	30% Coinsurance Deductible applies first	Not covered	Preauthorization required.

If you have Outpatient Surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Physician/surgeon fees	30% Coinsurance Deductible applies first	Not covered	Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Professional Office Visits	$25 Copay/visit Deductible does not apply	Not covered	Preauthorization required for MH/SA intensive (extended) or residential services and Applied Behavioral Analysis (ABA) therapy.
	Outpatient services	30% Coinsurance Deductible applies first	Not covered	
	Inpatient services	30% Coinsurance Deductible applies first	Not covered	Preauthorization required.
If you are pregnant	Office visits	30% Coinsurance Deductible applies first	Not covered	Preauthorization required for Inpatient stay that exceeds the 48/96-hour timeframe as outlined in the Evidence of Coverage (EOC). Cost-sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% Coinsurance Deductible applies first	Not covered	
	Childbirth/delivery facility services	30% Coinsurance Deductible applies first	Not covered	
Oral Contraceptives & contraceptive services and devices	All FDA approved devices - educational services & counseling	No charge	Not covered	Not subject to Copayment for Generic or Brand Name Formulary Drugs, if Generic Drug not available.
If you need help recovering or have special health needs	Home Health Care	30% Coinsurance Deductible applies first	Not covered	Limited to 60 visits per Year. Preauthorization required

If you need help recovering or have special health needs	Skilled Nursing Care	30% Coinsurance Deductible applies first	Not covered	Limited to 25 days per Year. Preauthorization required.
	Prosthetic & Orthotic devices (appliances)	30% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Durable Medical Equipment	30% Coinsurance Deductible applies first	Not covered	Preauthorization required for items exceeding $500.
	Hospice Service	30% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Hearing aids & Cochlear implants	30% Coinsurance Deductible applies first	Not covered	Hearing aids & Cochlear implants limited to one (1) pair OR one (1) implant every 36 months. Preauthorization required.
	Rehabilitation services	30% Coinsurance Deductible applies first	Not covered	PT/OT/ST/Chiro – Limited to 35 combined visits for Rehabilitation Services and 35 combined visits for Habilitation Services across physical medical services per Plan Year. Plan Limitations do not apply to Medically Necessary services or services related to Autism Spectrum Disorder. Preauthorization required for Inpatient & ABA in Cognitive Therapy. Cardio/Pulmonary Rehabilitation limited to 36 visits for Cardiac Rehab and 36 visits for Pulmonary Rehab.
	Habilitation services	30% Coinsurance Deductible applies first	Not covered	
	Physical Therapy (PT) & Occupational Therapy (OT) & Speech Therapy (ST)	30% Coinsurance Deductible applies first	Not covered	
	Chiropractic care	30% Coinsurance Deductible applies first	Not covered	
	Speech & hearing exams	$25 Copay/visit Deductible does not apply	Not covered	None

If your child needs dental or eye care	Children's dental checkup	Class A - No charge, Class B, C, D and general pediatric dental - 50% Coinsurance/visit	Not covered	Out-of-Pocket Maximum applies to Class B, C, and D & general pediatric dental for Children Preauthorization is required for Classes C and D only. Subject to Plan Exclusions.
	Children's eye exam	$50 Copay/visit Deductible does not apply	Not covered	Limited to one (1) eye exam/year for children under age19.
	Children’s glasses	30% Coinsurance Deductible applies first	Not covered	Limited to one (1) pair of eyeglasses OR one (1) pair of contact lenses/Year for Children under age 19. Subject to Plan Limitations. Maximum cost allowed $150.
Other professional services	Radiation & chemotherapy	30% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Transplant	30% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Routine foot care	30% Coinsurance Deductible applies first	Not covered	None
	Infusion therapy	30% Coinsurance Deductible applies first	Not covered	Preauthorization required.
	Allergy testing	30% Coinsurance Deductible applies first	Not covered	None
	Dialysis	30% Coinsurance Deductible applies first	Not covered	None
	Telehealth or Telemedicine services	No charge	Not covered	Copayment, Coinsurance, and Deductible amounts will not exceed amount for comparable medical services provided through a face-to-face consultation.

Pharmacy Schedule of Benefits				
		Network Provider	**Out-of-Network Provider**	**Exclusions & Limitations and Other Important Information**
If you need Drugs to treat your Illness or condition	Generic Drugs	Retail: $4 Copay/ Prescription Deductible does not apply	Not covered	Retail covers 30-day supply and mail order covers up to 90-day supply unless stated by the Formulary or the Plan Benefits. Network Provider Prescription Drug Copayment applies to the Out-of-Pocket Maximum. Member responsible for paying applicable Copay, allowable Claim amount, or the contracted rate of the Prescription, if less than the established Copay. Cost-sharing for insulin on the Formulary will not exceed $25 per Prescription for a 30-day supply. Prior Authorization is required for some Drugs. Some Prescription Drugs and/or medications are not available through the mail order service. Some Specialty Drugs are subject to Utilization Review or Prior Authorization. 30-day supply only; 90-day mail order not covered.
		Mail order: $10 Copay/ Prescription Deductible does not apply	Not covered	
	Preferred Brand Drugs	Retail: $35 Copay/ Prescription Deductible does not apply	Not covered	
		Mail order: $87.50 Copay/ Prescription Deductible does not apply	Not covered	
	Non-Preferred Brands / Drugs	Retail: $65 Copay/ Prescription Deductible does not apply	Not covered	
		Mail order: $162.50 Copay/ Prescription Deductible does not apply	Not covered	
	Specialty Drugs	Retail: 45% Coinsurance Deductible applies first	Not covered	
		Mail order: Not covered	Not covered	

Pediatric Dental Schedule of Benefits				
Benefit Payment Details:	• Classes C and D are subject to Pre-Authorization or there will be a 50% reduction in benefits. • Services available for children under age 19 only.			
Category	**Services You May Need**	**Participating Provider (In-Network)**	**Non-Participating Provider (Out-of-Network)**	**Exclusions & Limitations**
Class A Pediatric Dental Services (Basic Services)	Diagnostic & Treatment Services Preventive Services Minor procedures related to Emergency Services	$0 Copay Deductible does not apply	Not Covered	
Class B Pediatric Dental Services (Intermediate Services)	Minor Restorative Services Endodontic Services* Periodontal Services* Prosthodontic Services* Oral Surgery	50% Coinsurance Deductible applies first	Not Covered	
Class C Pediatric Dental Services (Major Services)	Major Restorative Services Endodontic Services** Periodontal Services** Prosthodontic Services** Implants**	50% Coinsurance Deductible applies first	Not Covered	Preauthorization required
Class D Pediatric Dental Services (Orthodontic)	Orthodontic treatment as a result of congenital or developmental malformation which are related to or developed as a result of cleft palette with or without cleft lip	50% Coinsurance Deductible applies first	Not Covered	Preauthorization required
General Pediatric Dental Services	Anesthesia Services Intravenous Sedation Consultations Medications Post Surgical Services	50% Coinsurance Deductible applies first	Not Covered	

CLASS A PEDIATRIC DENTAL SERVICES - BASIC SERVICES	
Dental Pocedure Code	***Diagnostic and Treatment Services***
D0120	Periodic oral evaluation -Limited to 1 every 6 months
D0140	Limited oral evaluation - problem focused - Limited to 1 every 6 months
D0150	Comprehensive oral evaluation, new or established patient - Limited to 1 every 6 months
D0180	Comprehensive periodontal evaluation, new or established patient - Limited to 1 every 6 months
D0210	Intraoral – complete series of radiographic images - 1 every 60 (sixty) months
D0220	Intraoral - periapical first radiographic image
D0230	Intraoral - periapical each additional radiographic image
D0240	Intraoral - occlusal radiographic image
D0270	Bitewing – single radiographic image - 1 set every 6 months
D0272	Bitewings – two radiographic images -1 set every 6 months
D0273	Bitewings – three radiographic images -1 set every 6 months
D0274	Bitewings – four radiographic images - 1 set every 6 months
D0277	Vertical bitewings – 7 to 8 radiographic images - 1 set every 6 months
D0330	Panoramic radiographic image – 1 film every 60 (sixty) months
D0340	Cephalometric radiographic image
D0350	2-D Oral/ Facial photographic image obtained intra-orally or extra-orally
D0391	Interpretation of Diagnostic Image
D0470	Diagnostic casts
Dental Procedure Code	***Preventive Services***
D1120	Prophylaxis – Child - Limited to 1 every 6 months
D1206	Topical fluoride varnish - 2 in 12 months
D1208	Topical application of fluoride (excluding prophylaxis) – child less than age 19 - Limited to 2 every 12 months
D1351	Sealant per tooth (for children under 14) - unrestored permanent molars - 1 sealant per tooth every 36 months
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months.
D1510	Space Maintainer – fixed – unilateral
D1515	Space Maintainer – fixed – bilateral
D1520	Space Maintainer - removable – unilateral
D1525	Space maintainer - removable – bilateral
D1550	Re-cement or re-bond Space Maintainer
Dental Procedure Code	***Additional Procedures Covered as Basic Services***
D9110	Palliative (emergency) treatment of dental pain – minor procedure

CLASS B PEDIATRIC DENTAL SERVICES - INTERMEDIATE SERVICES	
Dental Procedure Code	***Minor Restorative Services***
D2140	Amalgam - one surface, primary/permanent
D2150	Amalgam - two surfaces, primary/permanent
D2160	Amalgam - three surfaces, primary/permanent
D2161	Amalgam - four or more surfaces, primary/permanent
D2330	Resin one surface – anterior
D2331	Resin two surfaces – anterior
D2332	Resin three surfaces – anterior
D2335	Resin-based composite - four or more surfaces, or involving incisal angle (anterior)
D2910	Re-cement ore re-bond inlay, onlay, veneer or partial coverage restoration
D2920	Re-cement or re-bond crown
D2929	Prefabricated porcelain crown - primary tooth - Limited to 1 every 60 months
D2930	Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months
D2931	Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months
D2940	Protective Restoration
D2951	Pin retention - per tooth, in addition to restoration

Dental Procedure Code	***Endodontic Services***
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for Insureds up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration). Incomplete endodontic treatment when You discontinue treatment. - Limited to primary incisor teeth for Insureds up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.

Dental Procedure Code	Periodontal Services
D4271	Free soft tissue graft procedure (including donor site surgery)
D4341	Periodontal scaling and root planing - four or more teeth per quadrant – Limited to 1 every 24 months
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant – Limited to 1 every 24 months
D4910	Periodontal maintenance procedures (following active therapy) - 4 in 12 months combined with prophylaxis after the completion of active periodontal therapy
D7921	Collect - Apply Autologus Product - Limited to 1 in 36 months
Dental Procedure Code	***Prosthodontic Services - (Removable & Fixed)***
D5410	Adjust complete denture – maxillary
D5411	Adjust complete denture – mandibular
D5421	Adjust partial denture – maxillary
D5422	Adjust partial denture - mandibular
D5510	Repair broken complete denture base
D5520	Replace missing or broken teeth - complete denture (each tooth)
D5610	Repair resin denture base
D5620	Repair cast framework
D5630	Repair or replace broken clasp
D5640	Replace broken teeth - per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture
D5710	Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5720	Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5721	Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5730	Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5731	Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5740	Reline maxillary partial denture - Limited to 1in a 36-month period 6 months after the initial installation
D5741	Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5750	Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5751	Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5760	Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5761	Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.

D5850	Tissue conditioning (maxillary)
D5851	Tissue conditioning (mandibular)
D6930	Recement fixed partial denture
D6973	Core buildup for retainer, including any pins - 1 every 60 months
D6980	Fixed partial denture repair necessitated by restorative material failure
Dental Procedure Code	***Oral Surgery Services***
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
D7220	Removal of impacted tooth – soft tissue
D7230	Removal of impacted tooth – partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7251	Coronectomy - intentional partial tooth removal
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280	Surgical access of an unerupted tooth
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7321	Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7471	Removal of lateral exostosis (maxilla or mandible)
D7510	Incision and drainage of abscess - intraoral soft tissue
D7910	Suture of recent small wounds up to 5 cm
D7953	Bone replacement graft for ridge preservation-per site
D7971	Excision of pericoronal gingiva

CLASS C PEDIATRIC DENTAL SERVICES - MAJOR	
Dental Procedure Code	***Major Restorative Services***
NOTE: When dental services that are subject to a frequency limitation were performed prior to your effective date of coverage the date of the prior service may be counted toward the time, frequency limitations and/ or replacement limitations under this dental insurance. (For example, even if a crown, partial bridge, etc was not placed while covered under our plan or paid by our plan, the frequency limitations may apply).	
D0160	Detailed and extensive oral evaluation - problem focused, by report
D2510	Inlay - metallic – one surface – An alternate benefit will be provided
D2520	Inlay - metallic – two surfaces – An alternate benefit will be provided

D2530	Inlay - metallic – three surfaces – An alternate benefit will be provided
D2542	Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months
D2543	Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months
D2544	Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months
D2740	Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
D2750	Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
D2751	Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months
D2752	Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
D2780	Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months
D2781	Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months
D2783	Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months
D2790	Crown - full cast high noble metal– Limited to 1 per tooth every 60 months
D2791	Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months
D2792	Crown - full cast noble metal– Limited to 1 per tooth every 60 months
D2794	Crown – titanium– Limited to 1 per tooth every 60 months
D2950	Core buildup, including any pins when required – Limited to 1 per tooth every 60 months
D2954	Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months
D2980	Crown repair necessitated by restorative material failure
D2981	Inlay Repair
D2982	Onlay Repair
D2983	Veneer Repair
D2990	Resin infiltration/smooth surface - Limited to 1 in 36 months
Dental Procedure Code	***Endodontic Services***
D3310	Endodontic therapy/Anterior root canal (excluding final restoration)
D3320	Endodontic therapy/Bicuspid root canal (excluding final restoration)
D3330	Endodontic therapy/Molar root canal (excluding final restoration)
D3346	Retreatment of previous root canal therapy-anterior
D3347	Retreatment of previous root canal therapy-bicuspid
D3348	Retreatment of previous root canal therapy-molar
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353	Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)

D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
D3410	Apicoectomy/periradicular surgery - anterior
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)
D3425	Apicoectomy/periradicular surgery - molar (first root)
D3426	Apicoectomy/periradicular surgery (each additional root)
D3450	Root amputation - per root
D3920	Hemisection (including any root removal) - not including root canal therapy

Dental Procedure Code	***Periodontal Services****
D4210	Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months
D4211	Gingivectomy or gingivoplasty – one to three teeth - Limited to 1 every 36 months
D4212	Gingivectomy or gingivoplasty - with restorative procedures, per tooth - Limited to 1 every 36 months
D4240	Gingival flap procedure, including root planing - four or more teeth – Limited to 1 every 36 months
D4241	Gingival flap procedure, including root planning - one to three contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months
D4249	Clinical crown lengthening-hard tissue
D4260	Osseous surgery (including elevation of a full thickness flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
D4261	Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant - Limited to 1 every 36 months
D4263	Bone replacement graft - first site in quadrant - Limited to 1 every 36 months
D4270	Pedicle soft tissue graft procedure
D4273	Subepithelial connective tissue graft procedures, per tooth
D4275	Soft tissue allograft - Limited to 1 every 36 months
D4277	Free soft tissue graft 1st tooth
D4278	Free soft tissue graft-additional teeth
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime
Dental Procedure Code	***Prosthodontic Services****
D5110	Complete denture - maxillary – Limited to 1 every 60 months
D5120	Complete denture - mandibular – Limited to 1 every 60 months
D5130	Immediate denture - maxillary – Limited to 1 every 60 months
D5140	Immediate denture - mandibular – Limited to 1 every 60 months
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5281	Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months

Note: An **implant** is a covered procedure of the plan only if determined to be a dental necessity. Our claim review is conducted by a panel of licensed dentists who review the clinical documentation submitted by your treating dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.	
D6010	Endosteal Implant (surgical placement of implant body) - 1 every 60 months
D6012	Surgical Placement of Interim Implant Body - 1 every 60 months
D6040	Eposteal Implant – 1 every 60 months
D6050	Transosteal Implant (surgical placement), Including Hardware – 1 every 60 months
D6053	Implant/abutement supported completely removable denture
D6054	Implant/abutement supported removable denture partial denture
D6055	Connecting Bar – implant or abutment supported - 1 every 60 months
D6056	Prefabricated Abutment – includes modification and placement – 1 every 60 months
D6057	Custom Abutment - 1 every 60 months
D6058	Abutment supported porcelain/ceramic crown -1 every 60 months
D6059	Abutment supported porcelain fused to metal crown (high noble metal) - 1 every 60 months
D6060	Abutment supported porcelain fused to metal crown (predominately base metal) - 1 every 60 months
D6061	Abutment supported porcelain fused to metal crown (noble metal) - 1 every 60 months
D6062	Abutment supported cast metal crown (high noble metal) - 1 every 60 months
D6063	Abutment supported cast metal crown (predominately base metal) - 1 every 60 months
D6064	Abutment supported cast metal crown (noble metal) - 1 every 60 months
D6065	Implant supported porcelain/ceramic crown - 1 every 60 months
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) - 1 every 60 months
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal) - 1 every 60 months
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months
D6069	Abutment supported retainer for porcelain fused to metal fixed partial denture (high noble metal) - 1 every 60 months
D6070	Abutment supported retainer for porcelain fused to metal fixed partial denture (predominately base metal)- 1 every 60 months
D6071	Abutment supported retainer for porcelain fused to metal fixed partial denture (noble metal) - 1 every 60 months
D6072	Abutment supported retainer for cast high noble metal fixed partial denture - 1 every 60 months
D6073	Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months

D6074	Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months
D6075	Implant supported retainer for ceramic fixed partial denture - 1 every 60 months
D6076	Implant supported retainer for porcelain fused to metal fixed partial denture (titanium, titanium alloy, or high noble metal) - 1 every 60 months
D6077	Implant supported retainer for cast metal fixed partial denture (titanium, titanium alloy, or high noble metal) - 1 every 60 months
D6078	Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
D6079	Implant/abutment supported fixed denture for partially edentulous arch - 1 every 60 months
D6080	Implant Maintenance Procedures -1 every 60 months
D6090	Repair implant supported prosthesis, by report -1 every 60 months
D6091	Replacement of Semi-Precision or Precision Attachment (male or female component) of implant/abutment supported prosthesis, per attachment -1 every 60 months
D6095	Repair Implant Abutment , by report -1 every 60 months
D6100	Implant Removal, by report -1 every 60 months
D6101	Debridement perimplant defect, covered if implants are covered - Limited to 1 every 60 months
D6102	Debridement and osseous perimplant defect, covered if implants are covered - Limited to 1 every 60 months
D6103	Bone graft perimplant defect, covered if implants are covered
D6104	Bone graft implant replacement, covered if implants are covered
D6190	Implant IndexD6190 Radiographic/surgical implant index, by report -1 every 60 months
D6210	Pontic - cast high noble metal – Limited to 1 every 60 months
D6211	Pontic - cast predominately base metal – Limited to 1 every 60 months
D6212	Pontic - cast noble metal– Limited to 1 every 60 months
D6214	Pontic – titanium – Limited to 1 every 60 months
D6240	Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
D6241	Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months
D6242	Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
D6245	Pontic - porcelain/ceramic – Limited to 1 every 60 months
D6519	Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months
D6520	Inlay – metallic – two surfaces – Limited to 1 every 60 months
D6530	Inlay – metallic – three or more surfaces - Limited to 1 every 60 months
D6543	Onlay – metallic – three surfaces - 1 every 60 months
D6544	Onlay – metallic – four or more surfaces -1 every 60 months
D6545	Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
D6740	Crown - porcelain/ceramic -1 every 60 months
D6750	Crown - porcelain fused to high noble metal - 1 every 60 months
D6751	Crown - porcelain fused to predominately base metal - 1 every 60 months
D6752	Crown - porcelain fused to noble metal - 1 every 60 months
D6780	Crown - 3/4 cast high noble metal - 1 every 60 months
D6781	Crown - 3/4 cast predominately base metal - 1 every 60 months
D6782	Crown - 3/4 cast noble metal - 1 every 60 months
D6783	Crown - 3/4 porcelain/ceramic - 1 every 60 months
D6790	Crown - full cast high noble metal - 1 every 60 months
D6791	Crown - full cast predominately base metal - 1 every 60 months
D6792	Crown - full cast noble metal - 1 every 60 months
D9940	Occlusal guard, by report - 1 in 12 months for patients 13 and older

CLASS D PEDIATRIC DENTAL SERVICES - ORTHODONTIC	
Dental Procedure Code	***Orthodontic Services***
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8660	Pre-orthodontic treatment visit
D8670	Periodic orthodontic treatment visit (as part of contract)
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))
GENERAL PEDIATRIC DENTAL SERVICES	
Dental Procedure Code	***Anesthesia Services***
D9220	Deep sedation/general anesthesia - first 30 minutes
D9221	Deep sedation/general anesthesia - each additional 15 minutes
Dental Procedure Code	***Intravenous Sedation***
D9241	Intravenous conscious sedation/analgesia - first 30 minutes
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes
Dental Procedure Code	***Consultations***
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
Dental Procedure Code	***Medications***
D9610	Therapeutic drug injection, by report
Dental Procedure Code	***Post Surgical Services***
D9930	Treatment of complications (post-surgical) unusual circumstances, by report

LIST OF EXCLUSIONS AND THINGS WE DO NOT COVER	
Dental Procedure Code	***Exclusions & Services***
D0310	Sialography
D0320	Temporomandibular joint (TMJ) arthrogram, including injection
D0321	Other temporomandibular joint (TMJ) radiographic images, by report
D0322	Tomographic survey
D0416	Viral culture
D0418	Analysis of saliva (example chemical or biological analysis of saliva for diagnostic purposes)
D0425	Caries test
D0431	Adjunctive pre-diagnostic test

D0472	Oral Pathology lab (Accession of tissue, gross examination, preparation and transmission of written report)
D0473	Oral Pathology lab (Accession of tissue, gross and microscopic examination, preparation and transmission of written report)
D0474	Oral Pathology lab (Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation, and transmission of report)
D0475	Decalcification procedure
D0476	Special stains for microorganisms
D0477	Special stains not for microorganisms
D0478	Immunohistochemical stains
D0479	Tissue in-situ-hybridization, including interpretation
D0480	Oral Pathology lab
D0481	Electron microscopy - diagnostic
D0482	Direct immunofluorescence
D0483	In-direct immunofluorescence
D0484	Consultation on slides prepared elsewhere
D0485	Consultation including preparation of slides from biopsy material supplied by referring source
D0486	Accession Transepithelial (Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report)
D0502	Other oral pathology procedures, by report
D1310	Nutritional Counseling
D1320	Tobacco counseling
D1330	Oral Hygiene Instruction
D1555	Removal of fixed space maintainer
D2410	Gold Foil 1 surface
D2420	Gold Foil 2 surface
D2430	Gold Foil 3 surface
D2799	Provisional Crown
D2955	Post Removal
D2970	Temporary Crown
D2975	Coping
D3460	Endodontic Implant
D3470	Intentional reimplantation
D3910	Surgical procedure for isolation of tooth
D3950	Canal preparation
D4230	Anatomical crown exposure 4 or more teeth
D4231	Anatomical crown exposure 1-3 teeth
D4320	Splinting intracoronal

D4321	Splinting extracoronal
D5810	Complete denture upper (interim)
D5811	Complete denture lower (interim)
D5820	Partial denture upper (interim)
D5821	Partial denture lower (interim)
D5862	Precision Attachment
D5867	Replacement Precision Attachment
D5911	Facial Moulage (sectional)
D5912	Facial Moulage (complete)
D5913	Nasal Prosthesis
D5914	Auricular Prosthesis
D5915	Orbital Prosthesis
D5916	Ocular Prosthesis
D5919	Facial Prosthesis
D5922	Nasal Septal Prosthesis
D5923	Ocular Prosthesis (interim)
D5924	Cranial Prosthesis
D5925	Facial Augmentation implant prosthesis
D5926	Nasal Prosthesis (replacement)
D5927	Auricular Prosthesis (replacement)
D5928	Orbital Prosthesis (replacement)
D5929	Facial Prosthesis (replacement)
D5931	Obturator Prosthesis (surgical)
D5932	Obturator Prosthesis (definitive)
D5933	Obturator Prosthesis (modification)
D5934	Mandibular resection Prosthesis with guide flange
D5935	Mandibular resection Prosthesis without guide flange
D5936	Obturator Prosthesis (interim)
D5937	Trismus Appliance (not for TMD treatment)
D5951	Feeding Aid
D5952	Speech Aid prosthesis (pediatric)
D5954	Palatal Augmentation Prosthesis
D5955	Palatal Lift Prosthesis (definitive)
D5958	Palatal Lift Prosthesis (interim)
D5959	Palatal Lift Prosthesis (modification)
D5960	Speech Aid Prosthesis (modification)
D5982	Surgical Stent
D5983	Radiation Carrier
D5984	Radiation Shield
D5985	Radiation Cone locator
D5986	Fluoride Gel Carrier
D5987	Commissure Splint
D5988	Surgical Splint

D5992	Adjust maxillofacial prosthetic appliance, by report
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
D6051	Interim Abutment
D6199	Unspecified Implant Procedure, by report
D6253	Provisional Pontic – further treatment or completion of diagnosis necessary prior to final impression.
D6793	Provisional retainer Crown
D6920	Connector bar
D6940	Stress breaker
D6950	Precision Attachment
D6975	Coping
D7285	Biopsy of oral tissue – hard (bone, tooth)
D7286	Biopsy of oral tissue (soft)
D7292	Surgical placement: temporary anchorage device (screw retained plate) requiring surgical flap
D7293	Surgical placement: temporary anchorage device requiring surgical flap
D7294	Surgical placement: temporary anchorage device without surgical flap
D7295	Harvest of bone for use in autogenous grafting procedure
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm
D7460	Removal of Benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7461	Removal of Benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7490	Radical resection of maxilla or mandible
D7530	Removal of foreign body
D7540	Removal of reaction producing foreign bodies, musculoskeletal system
D7550	Partial Ostectomy/sequestrectomy for removal of non-vital bone
D7560	Maxillary Sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla – open reduction
D7620	Maxilla – closed reduction
D7630	Mandible – open reduction
D7640	Mandible – closed reduction

D7650	Malar and/or zygomatic arch – open reduction
D7660	Malar and/or zygomatic arch – closed reduction
D7670	Alveolus, closed reduction
D7671	Alveolus, open reduction
D7680	Facial bones (simple)
D7710	Maxilla – open reduction
D7720	Maxilla – closed reduction
D7730	Mandible - open reduction
D7740	Mandible – closed reduction
D7750	Malar and/or zygomatic arch open red.(compound)
D7760	Malar and/or zygomatic arch closed red.(compound)
D7770	Alveolus open red.(compound - stabilization of teeth)
D7771	Alveolus closed red. (compound – stabilization of teeth)
D7780	Facial bones - complicated
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-Arthroscopic lysis and lavage
D7872	Arthroscopy – diagnosis, with or without a biopsy
D7873	Arthoscopy - surgical
D7874	Arthoscopy surgical disc
D7875	Arthoscopy surgical: synovectomy
D7876	Arthoscopy surgical: discectomy
D7877	Arthoscopy surgical: debridement
D7880	TMJ Appliance (Occlusal orthotic device, by report)
D7899	TMJ Therapy
D7911	Complicated suture - up to 5 cm.
D7912	Complicated suture - greater than 5 cm.
D7920	Skin graft
D7940	Osteoplasty deformities
D7941	Osteotomy mandibular rami
D7943	Osteotomy mandibular rami with bone graft
D7944	Osteotomy segmented or subapical
D7945	Osteotomy body of mandible

D7946	Lefort I (maxilla – total)
D7947	Lefort I (maxilla – segmented)
D7948	Lefort II or Lefort III without bone graft
D7949	Lefort II or Lefort III with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla, autogenous or nonautogenous by report
D7951	Sinus Augmentation – Lateral, with bone or bone substitutes
D7955	Repair of Maxillofacial soft and/or hard tissue defect
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft – mandible or facial bones, by report
D7996	Implant-mandible for augmentation purposes (excluding alveolar ridge), by report
D7997	Appliance Removal (not by dentist who placed appliance), includes removal of archbar
D7998	Intraoral placement of a fixation device not in conjunction with a fracture
D9210	Local Anesthesia not in conjunction with operative or surgical procedures
D9211	Regional Block Anesthesia
D9212	Trigeminal Division Block Anesthesia
D9215	Local Anesthesia
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9248	Non-intravenous conscious sedation
D9410	House/extended care facility call
D9420	Hospital Call
D9450	Case presentation
D9630	Other drugs and or medicaments
D9920	Behavior Management
D9941	Fabrication of athletic mouthguard
D9950	Occlusion analysis - mounted case
D9951	Occlusal adjustment - limited
D9952	Occlusal adjustment - complete
D9970	Enamel microabrasion
D9971	Odontoplasty 1-2 teeth
D9972	External bleaching - per arch
D9973	External bleaching - per tooth
D9974	Internal bleaching - per tooth
D9975	External bleaching - per arch

· Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth
· Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice
· Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances
· Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ)
· Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group
· Services and treatment resulting from Your failure to comply with professionally prescribed treatment
· Any charges for failure to keep a scheduled appointment
· Office infection control charges
· State or territorial taxes on dental services performed
· Service charges submitted by a dentist, which are for the same services performed on the same date for the same Insured Person by another dentist
· Service charges provided free of charge by any governmental unit, except where this exclusion is prohibited by law
· Those performed by a dentist who is compensated by a facility for similar covered services performed for Insureds
· Duplicate, provisional and temporary devices, appliances, and services
· Plaque control programs, oral hygiene instruction, and dietary instructions

· Gold foil restorations
· Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan
· Charges by the provider for completing dental forms
· Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it
· Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners
· Sealants for teeth other than permanent molars
· Precision attachments, personalization, precious metal bases and other specialized techniques
· Replacement of dentures that have been lost, stolen or misplaced
· Any other services excluded under the “Exclusions and Limitations: What the Plan Does Not Pay For” section of this Plan
· Repair of damaged orthodontic appliances
· Replacement of lost or missing appliances
· Fabrication of athletic mouth guard
· Nitrous oxide
· Oral sedation
· Topical medicament center
· Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.
· When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non benefited service) as determined by Us.

· When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by Us.
· Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law.
· Services and treatment which are experimental or investigational
· Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation
· Services and treatment performed prior to your effective date of coverage
· Services and treatment incurred after the termination date of your coverage unless otherwise indicated
· Telephone consultations
· Services or treatment provided as a result of intentionally self-inflicted injury or illness
· Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection
· Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays
· Charges for which the member would have no obligation to pay in the absence of this or any similar coverage
· Charges which are for specialized procedures and techniques

· Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization
· Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient)
· Cone Beam Imaging and Cone Beam MRI procedures
· Orthodontic care for dependent children age 19 and over
· Internal and external bleaching
** **NOTE:** All out of network services listed in Section 5 are subject to the usual and customary maximum allowable fee charges as defined in the Evidence of Coverage. The member is responsible for all remaining charges that exceed the allowable maximum.