2021 Dental Fee Schedule

MEMORIAL HERMANN Health Plan

MEMORIAL HERMANN *ADVANTAGE* HMO

DENTAL BENEFITS ADDENDUM

MEMORIAL HERMANN HEALTH SOLUTIONS

Memorial Hermann Advantage HMO

Administered by:

Delta Dental Insurance Company

Evidence of Coverage for Memorial Hermann Advantage HMO Dental Benefits Addendum

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INTRODUCTION

We are pleased to welcome you to the dental plan for Memorial Hermann Advantage HMO. Your plan is administered by Delta Dental Insurance Company ("Delta Dental"). Our goal is to provide you with high quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

This plan is available in the following county: *Fort Bend, Harris, Montgomery*

Using This Evidence of Coverage

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

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

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

Contact Us

For more information please visit www.deltadentalins.com/MHHPMedicareAdvantage or call Delta Dental's Customer Service Center at (888) 845-6023 (TTY 711). A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Delta Dental Participating Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access Delta Dental's automated information line at (888) 845-6023 (TTY 711) during regular business hours to obtain information about Member's eligibility and Benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write Delta Dental with your question(s), please mail your inquiry to the following address:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

DEFINITIONS

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

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

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

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

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

Contract-- the Agreement between Memorial Hermann Health Solutions and Delta Dental Insurance Company for the Provision of Dental Services.

Contractholder – Memorial Hermann Health Solutions.

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

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

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

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

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

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

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

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

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

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

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

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

How to use this Plan - Choice of Participating Provider

To receive Benefits under this Plan, you must select a Participating Provider from the directory of Participating Providers. If you fail to select a Participating Provider or the Participating Provider selected by you becomes unavailable, we will request you select another Participating Provider or we will assign you to a Participating Provider. You may change your assigned Participating Provider by directing a request to the Customer Service department at (888) 845-6023 Monday through Friday from 8 a.m. to 8 p.m. local time (TTY users call 711). In order to ensure that your Participating Provider is notified and our eligibility lists are correct, changes in Participating Providers must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a membership packet that tells you the effective date of your Plan and the address and telephone number of your Participating Provider. After the effective date in your membership packet, you may obtain dental services under the Plan. To make an appointment simply call your Participating Provider's facility and identify yourself as a Member through Memorial Hermann Advantage HMO. Inquiries regarding availability of appointments and accessibility of Participating Providers should be directed to the Customer Service department at (888) 845-6023 (TTY users 711).

EACH MEMBER MUST GO TO HIS OR HER ASSIGNED PARTICIPATING PROVIDER TO OBTAIN COVERED SERVICES. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PLAN.

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

Continuity of Care

Existing Members:

You may have the right to have completion of care with your terminated Participating Provider for certain specified dental conditions. Please call Customer Service at (888) 845-6023 Monday through Friday from 8 a.m. to 8 p.m. local time (TTY users call 711) to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Participating Provider. We are not required to continue your care with that Participating Provider if you are not eligible for coverage under the Plan or if we cannot reach agreement with your terminated Participating Provider on the terms regarding your care.

New Members:

You may have the right to the qualified benefit of completion of care with a Non Participating Provider for certain specified dental conditions. Please call the Customer Service department at (888) 845-6023 Monday through Friday from 8 a.m. to 8 p.m. local time (TTY users call 711) to see if you may be eligible for this benefit. You may request a copy of our Continuity of Care Policy. You must make a specific request to continue under the care of your current Non Participating Provider. We are not required to continue your care with that dentist if you are not eligible under the Plan or if we cannot reach agreement with your dentist on the terms regarding your care.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at (888) 845-6023 Monday through Friday from 8 a.m. to 8 p.m. local time (TTY users call 711).

Benefits, Limitations and Exclusions

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

Copayments and Other Charges

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

Second Opinion

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

Second opinions will be rendered by a licensed dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at (888) 845-6023 Monday through Friday from 8 a.m. to 8 p.m. local time (TTY users call 711) or write to Delta Dental.

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

Claims for Reimbursement

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

Provider Compensation

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

In the event we fail to pay a Participating Provider, you will not be liable to that Participating Provider for any sums owed by us. The Participating Provider's contract with Delta Dental contains a provision prohibiting the Participating Provider from charging a Member for any sums owed by Delta Dental. **You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number listed in this booklet.**

Processing Policies

The dental care guidelines for the Plan explain to Participating Providers what services are covered under the dental Contract. Participating Providers will use their professional judgment to determine which services are appropriate for the Member. Services performed by the Participating Provider that fall under the scope of Benefits of the dental Plan are provided subject to any Copayments. A Member may contact Delta Dental's Customer Service department at (888) 845-6023 Monday through Friday from 8 a.m. to 8 p.m. local time (TTY users call 711) for information regarding the dental care guidelines for the Plan.

Coordination of Benefits

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

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

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

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

Grievance and Appeals Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Participating Providers to the courtesy extended you by our telephone representatives. If you have any question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Participating Provider, you have the right to file a grievance or appeal with Memorial Hermann Advantage HMO. See your Memorial Hermann Advantage HMO Evidence of Coverage Booklet

for information on the grievance process or contact Memorial Hermann Advantage HMO at (888) 845-6023.

Renewal and Termination of Benefits

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

Cancellation of Enrollment

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

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	I. DIAGNOSTIC	
	GP means General Practitioner.	
	SP means Specialty Care Practitioner.	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused *(GP)*	No Cost
D0140	Limited oral evaluation - problem focused *(SP)*	$20.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient *(GP)*	No Cost
D0150	Comprehensive oral evaluation - new or established patient *(SP)*	$20.00
D0160	Detailed and extensive oral evaluation - problem focused, by report *(GP)*	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report *(SP)*	$20.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient *(GP)*	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient *(SP)*	$20.00
D0190	Screening of a patient	No Cost

D0191 Assessment of a patient.....No Cost

D0210 Intraoral - complete series of radiographic images.....No Cost

D0220 Intraoral - periapical first radiographic image .....No Cost

D0230 Intraoral - periapical each additional radiographic image .....No Cost

D0240 Intraoral - occlusal radiographic image .....No Cost

D0270 Bitewing - single radiographic image.....No Cost

D0272 Bitewings - two radiographic images .....No Cost

D0273 Bitewings - three radiographic images .....No Cost

D0274 Bitewings - four radiographic images.....No Cost

D0277 Vertical bitewings - 7 to 8 radiographic images .....No Cost

D0330 Panoramic radiographic image .....No Cost

D0460 Pulp vitality tests.....No Cost

D0470 Diagnostic casts .....No Cost

D0601 Caries risk assessment and documentation, with a finding of low risk

- 1 every 3 years.....No Cost

D0602 Caries risk assessment and documentation, with a finding of moderate risk

- 1 every 3 years.....No Cost

D0603 Caries risk assessment and documentation, with a finding of high risk

- 1 every 3 years.....No Cost

D0999 Unspecified diagnostic procedure, by report

- includes office visit, per visit (in addition to other services).....No Cost

D1000-D1999 II. PREVENTIVE

D1110 Prophylaxis *cleaning* – adult

- 1 D1110, D1120 or D4346 per 6 month period [2] .....No Cost

D1120 Prophylaxis *cleaning* - child

- 1 D1110, D1120 or D4346 per 6 month period [2] .....No Cost

D1206 Topical application of fluoride varnish

- child to age 19; 1 D1206 or D1208 per 6 month period [2] .....No Cost

D1208 Topical application of fluoride - excluding varnish

- *child to age 19; 1 D1206 or D1208 per 6 month period* [2] .....No Cost

D1330 Oral hygiene instructions .....No Cost

D1351 Sealant - per tooth - *limited to permanent molars through age 15* $10.00

D1352 Preventive resin restoration in a moderate to high caries risk patient

- permanent tooth - *limited to permanent molars through age 15* $10.00

D1353 Sealant repair - per tooth - *limited to permanent molars through age 15* $10.00

D1354 Interim caries arresting medicament application

- per tooth - *child to age 19; 1 per 6 month period* .....No Cost

D1510 Space maintainer - fixed - unilateral $55.00

D1516 Space maintainer - fixed - bilateral, maxillary $55.00

D1517 Space maintainer - fixed - bilateral, mandibular $55.00

D1520 Space maintainer - removable - unilateral $55.00

D1526 Space maintainer - removable - bilateral, maxillary $55.00

D1527 Space maintainer - removable - bilateral, mandibular $55.00

D1550 Re-cement or re-bond space maintainer $10.00

D1555 Removal of fixed space maintainer $10.00

D1575 Distal shoe space maintainer - fixed - unilateral - *child to age 9* $55.00

D2000-D2999 III. RESTORATIVE

- *Includes indirect pulp capping, bases, liners and acid etch procedures.*

D2140 Amalgam - one surface, primary or permanent $20.00

D2150 Amalgam - two surfaces, primary or permanent $22.00

D2160 Amalgam - three surfaces, primary or permanent $24.00

D2161 Amalgam - four or more surfaces, primary or permanent $26.00

D2330 Resin-based composite - one surface, anterior $21.00

D2331 Resin-based composite - two surfaces, anterior $26.00

D2332 Resin-based composite - three surfaces, anterior $30.00

D2335 Resin-based composite - four or more surfaces or

involving incisal angle (anterior) $35.00

D2390 Resin-based composite crown, anterior $50.00

D2391	Resin-based composite - one surface, posterior	Optional
D2392	Resin-based composite - two surfaces, posterior	Optional
D2393	Resin-based composite - three surfaces, posterior	Optional
D2394	Resin-based composite - four or more surfaces, posterior	Optional
D2410	Gold foil - one surface	Optional
D2420	Gold foil - two surfaces	Optional
D2430	Gold foil - three surfaces	Optional
D2510	Inlay - metallic - one surface [4]	$180.00
D2520	Inlay - metallic - two surfaces [4]	$190.00
D2530	Inlay - metallic - three or more surfaces [4]	$200.00
D2542	Onlay - metallic - two surfaces [4]	$196.00
D2543	Onlay - metallic - three surfaces [4]	$206.00
D2544	Onlay - metallic - four or more surfaces [4]	$212.00
D2610	Inlay - porcelain/ceramic - one surface	Optional
D2620	Inlay - porcelain/ceramic - two surfaces	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces	Optional
D2642	Onlay - porcelain/ceramic - two surfaces	Optional
D2643	Onlay - porcelain/ceramic - three surfaces	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces	Optional
D2650	Inlay - resin-based composite - one surface	Optional
D2651	Inlay - resin-based composite - two surfaces	Optional
D2652	Inlay - resin-based composite - three or more surfaces	Optional
D2662	Onlay - resin-based composite - two surfaces	Optional
D2663	Onlay - resin-based composite - three surfaces	Optional
D2664	Onlay - resin-based composite - four or more surfaces	Optional
D2710	Crown - resin-based composite (indirect) [3]	$120.00
D2720	Crown - resin with high noble metal [3, 4]	$225.00
D2721	Crown - resin with predominantly base metal [3]	$225.00
D2722	Crown - resin with noble metal [3]	$225.00
D2740	Crown - porcelain/ceramic [3]	$225.00

D2750	Crown - porcelain fused to high noble metal [3, 4]	$225.00
D2751	Crown - porcelain fused to predominantly base metal [3]	$225.00
D2752	Crown - porcelain fused to noble metal [3]	$225.00
D2780	Crown - 3/4 cast high noble metal [4]	$225.00
D2781	Crown - 3/4 cast predominantly base metal	$225.00
D2782	Crown - 3/4 cast noble metal	$225.00
D2783	Crown - 3/4 porcelain/ceramic [3]	$225.00
D2790	Crown - full cast high noble metal [4]	$225.00
D2791	Crown - full cast predominantly base metal	$225.00
D2792	Crown - full cast noble metal	$225.00
D2794	Crown - titanium [4]	$225.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$35.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	Optional
D2930	Prefabricated stainless steel crown - primary tooth	$55.00
D2931	Prefabricated stainless steel crown - permanent tooth	$55.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$55.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	Optional
D2940	Protective restoration	$16.00
D2941	Interim therapeutic restoration - primary dentition	$16.00
D2949	Restorative foundation for an indirect restoration	$20.00
D2950	Core buildup, including any pins when required	$20.00
D2951	Pin retention - per tooth, in addition to restoration	$20.00
D2952	Post and core in addition to crown, indirectly fabricated [4]	$20.00
D2953	Each additional indirectly fabricated post - same tooth [4]	$20.00
D2954	Prefabricated post and core in addition to crown	$20.00
D2957	Each additional prefabricated post - same tooth	$20.00

D2971 Additional procedures to construct new crown
under existing partial denture framework $45.00
D2980 Crown repair necessitated by restorative material failure.....$25+lab
D2981 Inlay repair necessitated by restorative material failure .....$25+lab
D2982 Onlay repair necessitated by restorative material failure.....$25+lab
D2983 Veneer repair necessitated by restorative material failure.....$25+lab
D2990 Resin infiltration of incipient smooth surface lesions
- *limited to permanent molars through age 15* $10.00

D3000-D3999 IV. ENDODONTICS

D3110 Pulp cap - direct (excluding final restoration) .....No Cost
D3120 Pulp cap - indirect (excluding final restoration) .....No Cost
D3220 Therapeutic pulpotomy (excluding final restoration)
- removal of pulp coronal to the dentinocemental junction
and application of medicament $16.00
D3221 Pulpal debridement, primary and permanent teeth $15.00
D3222 Partial pulpotomy for apexogenesis
- permanent tooth with incomplete root development $16.00
D3230 Pulpal therapy (resorbable filling)
- anterior, primary tooth (excluding final restoration) $16.00
D3240 Pulpal therapy (resorbable filling)
- posterior, primary tooth (excluding final restoration) $16.00
D3310 *Root canal* - endodontic therapy, anterior tooth
(excluding final restoration).....$60.00
D3320 *Root canal* - endodontic therapy, premolar tooth
(excluding final restoration).....$120.00
D3330 *Root canal* - endodontic therapy, molar tooth
(excluding final restoration).....$180.00
D3331 Treatment of root canal obstruction; non-surgical access.....$60.00
D3332 Incomplete endodontic therapy; inoperable,

unrestorable or fractured tooth.....$60.00

D3346 Retreatment of previous root canal therapy - anterior $72.00

D3347 Retreatment of previous root canal therapy - premolar $144.00

D3348 Retreatment of previous root canal therapy - molar $215.00

D3410 Apicoectomy - anterior $100.00

D3421 Apicoectomy - premolar (first root).....$100.00

D3425 Apicoectomy - molar (first root).....$100.00

D3426 Apicoectomy (each additional root).....$50.00

D3427 Periradicular surgery without apicoectomy $100.00

D3430 Retrograde filling - per root $50.00

D4000-D4999 V. PERIODONTICS

- *Includes preoperative and postoperative evaluations and treatment under a local anesthetic.*

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth
or tooth bounded spaces per quadrant.....$175.00

D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth
or tooth bounded spaces per quadrant.....$175.00

D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure,
per tooth $175.00

D4240 Gingival flap procedure, including root planning
- four or more contiguous teeth or tooth bounded spaces per quadrant.....$150.00

D4241 Gingival flap procedure, including root planning
- one to three contiguous teeth or tooth bounded spaces per quadrant $150.00

D4245 Apically positioned flap.....$150.00

D4249 Clinical crown lengthening - hard tissue $175.00

D4260 Osseous surgery (including elevation of a full thickness flap and closure)
- four or more contiguous teeth or tooth bounded spaces per quadrant.....$300.00

D4261 Osseous surgery (including elevation of a full thickness flap and closure)
- one to three contiguous teeth or tooth bounded spaces per quadrant $300.00

D4341 Periodontal scaling and root planing - four or more teeth per quadrant $45.00

D4342 Periodontal scaling and root planing - one to three teeth per quadrant $45.00

D4346 Scaling in presence of generalized moderate
or severe gingival inflammation - full mouth, after oral evaluation
- 1 D1110, D1120 or D4346 per 6 month period .....No Cost

D4355 Full mouth debridement to enable a comprehensive oral evaluation
and diagnosis on a subsequent visit $45.00

D4910 Periodontal maintenance $36.00

D4921 Gingival irrigation - per quadrant .....No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110 Complete denture - maxillary [5] $250.00

D5120 Complete denture - mandibular [5] $250.00

D5130 Immediate denture - maxillary [5] $325.00

D5140 Immediate denture - mandibular [5] $325.00

D5211 Maxillary partial denture - resin base
(including retentive/clasping materials, rests, and teeth) [5] $270.00

D5212 Mandibular partial denture - resin base
(including retentive/clasping materials, rests, and teeth) [5] $270.00

D5213 Maxillary partial denture - cast metal framework with resin denture bases
(including any conventional clasps, rests and teeth) [5] $295.00

D5214 Mandibular partial denture - cast metal framework with resin denture bases
(including any conventional clasps, rests and teeth) [5] $295.00

D5221 Immediate maxillary partial denture - resin base
(including any conventional clasps, rests and teeth).....$270.00

D5222 Immediate mandibular partial denture - resin base
(including any conventional clasps, rests and teeth).....$270.00

D5223 Immediate maxillary partial denture
- cast metal framework with resin denture bases
(including any conventional clasps, rests and teeth).....$295.00

D5224 Immediate mandibular partial denture

	- cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$295.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) [5]	Optional
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth) [5]	Optional
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	$270.00
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	$270.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5511	Repair broken complete denture base, mandibular	$25.00
D5512	Repair broken complete denture base, maxillary	$25.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$10.00
D5611	Repair resin partial denture base, mandibular	$25.00
D5612	Repair resin partial denture base, maxillary	$25.00
D5621	Repair cast partial framework, mandibular	$25.00
D5622	Repair cast partial framework, maxillary	$25.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$25.00
D5640	Replace broken teeth - per tooth	$10.00
D5650	Add tooth to existing partial denture	$10.00
D5660	Add clasp to existing partial denture - per tooth	$10.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165.00
D5710	Rebase complete maxillary denture	$50.00
D5711	Rebase complete mandibular denture	$50.00
D5720	Rebase maxillary partial denture	$50.00

D5721	Rebase mandibular partial denture	$50.00
D5730	Reline complete maxillary denture (chairside)	$30.00
D5731	Reline complete mandibular denture (chairside)	$30.00
D5740	Reline maxillary partial denture (chairside)	$30.00
D5741	Reline mandibular partial denture (chairside)	$30.00
D5750	Reline complete maxillary denture (laboratory)	$50.00
D5751	Reline complete mandibular denture (laboratory)	$50.00
D5760	Reline maxillary partial denture (laboratory)	$50.00
D5761	Reline mandibular partial denture (laboratory)	$50.00
D5820	Interim partial denture (maxillary)	No Cost
D5821	Interim partial denture (mandibular)	No Cost
D5850	Tissue conditioning, maxillary	$25.00
D5851	Tissue conditioning, mandibular	$25.00
D5863	Overdenture - complete maxillary	Optional
D5864	Overdenture - partial maxillary	Optional
D5865	Overdenture - complete mandibular	Optional
D5866	Overdenture - partial mandibular	Optional

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed

(each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

D6210	Pontic - cast high noble metal [4]	$225.00
D6211	Pontic - cast predominantly base metal	$225.00
D6212	Pontic - cast noble metal	$225.00
D6240	Pontic - porcelain fused to high noble metal [3, 4]	$225.00
D6241	Pontic - porcelain fused to predominantly base metal [3]	$225.00
D6242	Pontic - porcelain fused to noble metal [3]	$225.00

D6250	Pontic - resin with high noble metal [3, 4]	$225.00
D6251	Pontic - resin with predominantly base metal [3]	$225.00
D6252	Pontic - resin with noble metal [3]	$225.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Optional
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Optional
D6549	Retainer - for resin bonded fixed prosthesis	Optional
D6600	Retainer inlay - porcelain/ceramic, two surfaces	Optional
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	Optional
D6602	Retainer inlay - cast high noble metal, two surfaces [4]	$200.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces [4]	$200.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$180.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$190.00
D6606	Retainer inlay - cast noble metal, two surfaces	$190.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$200.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Optional
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Optional
D6610	Retainer onlay - cast high noble metal, two surfaces [4]	$206.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces [4]	$212.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$196.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$202.00
D6614	Retainer onlay - cast noble metal, two surfaces	$206.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$212.00
D6720	Retainer crown - resin with high noble metal [3, 4]	$225.00
D6721	Retainer crown - resin with predominantly base metal [3]	$225.00
D6722	Retainer crown - resin with noble metal [3]	$225.00
D6750	Retainer crown - porcelain fused to high noble metal [3, 4]	$225.00
D6751	Retainer crown - porcelain fused to predominantly base metal [3]	$225.00
D6752	Retainer crown - porcelain fused to noble metal [3]	$225.00
D6780	Retainer crown - 3/4 cast high noble metal [4]	$225.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$225.00

D6782 Retainer crown - 3/4 cast noble metal.....$225.00

D6790 Retainer crown - full cast high noble metal [4] $225.00

D6791 Retainer crown - full cast predominantly base metal.....$225.00

D6792 Retainer crown - full cast noble metal $225.00

D6930 Re-cement or re-bond fixed partial denture $15.00

D6940 Stress breaker $35.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- *Includes preoperative and postoperative evaluations and treatment under a local anesthetic.*

D7111 Extraction, coronal remnants - primary tooth $18.00

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal) .$18.00

D7210 Extraction, erupted tooth requiring removal of bone
and/or sectioning of tooth, and including elevation of mucoperiosteal flap
if indicated $30.00

D7220 Removal of impacted tooth - soft tissue $50.00

D7230 Removal of impacted tooth - partially bony $75.00

D7240 Removal of impacted tooth - completely bony.....$100.00

D7241 Removal of impacted tooth - completely bony,
with unusual surgical complications.....$100.00

D7250 Removal of residual tooth roots (cutting procedure) .....No Cost

D7251 Coronectomy - intentional partial tooth removal.....$100.00

D7286 Incisional biopsy of oral tissue-soft $25.00

D7310 Alveoloplasty in conjunction with extractions
- four or more teeth or tooth spaces, per quadrant $65.00

D7311 Alveoloplasty in conjunction with extractions
- one to three teeth or tooth spaces, per quadrant $65.00

D7320 Alveoloplasty not in conjunction with extractions
- four or more teeth or tooth spaces, per quadrant $85.00

D7321 Alveoloplasty not in conjunction with extractions
- one to three teeth or tooth spaces, per quadrant $85.00

D7471 Removal of lateral exostosis (maxilla or mandible) $65.00

D7472 Removal of torus palatinus $65.00

D7473 Removal of torus mandibularis.....$65.00

D7510 Incision and drainage of abscess - intraoral soft tissue.....No Cost

D7960 Frenulectomy - also known as frenectomy or frenotomy

- separate procedure not incidental to another procedure $50.00

D8000-D8999 XI. ORTHODONTICS

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes:.....$200.00

D0210 Intraoral - complete series of radiographic images

D0322 Tomographic survey

D0330 Panoramic radiographic image

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

D0350 2D oral/facial photographic images obtained intraorally or extraorally

D0351 3D photographic image

D0470 Diagnostic casts

The benefit for post-treatment records includes:.....$70.00

D0210 Intraoral - complete series of radiographic images

D0470 Diagnostic casts

D8020 Limited orthodontic treatment of the transitional dentition [1] $1,950.00

D8030 Limited orthodontic treatment of the adolescent dentition [1] $1,950.00

D8040 Limited orthodontic treatment of the adult dentition [1] $2,150.00

D8070 Comprehensive orthodontic treatment of the transitional dentition [1] $1,950.00

D8080 Comprehensive orthodontic treatment of the adolescent dentition [1] $1,950.00

D8090 Comprehensive orthodontic treatment of the adult dentition [1] $2,150.00

D8660 Pre-orthodontic treatment examination to monitor growth and development

(*applied to treatment fee if patient proceeds with treatment*).....$25.00

D8670 Periodic orthodontic treatment visit - *Inclusive of treatment fee*.....No Cost

D8680 Orthodontic retention

(removal of appliances, construction and placement of retainer(s)) [1] .....No Cost

D8681 Removable orthodontic retainer adjustment .....No Cost

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110 Palliative (emergency) treatment of dental pain - minor procedure $15.00

D9211 Regional block anesthesia.....No Cost

D9212 Trigeminal division block anesthesia.....No Cost

D9215 Local anesthesia in conjunction with operative or surgical procedures .....No Cost

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.....No Cost

D9310 Consultation - diagnostic service provided by dentist
or physician other than requesting dentist or physician.....$25.00

D9311 Consultation with medical health care professional .....No Cost

D9430 Office visit for observation (during regularly scheduled hours)
- no other services performed $5.00

D9440 Office visit - after regularly scheduled hours $20.00

D9450 Case presentation, detailed and extensive treatment planning.....No Cost

D9932 Cleaning and inspection of removable complete denture, maxillary.....No Cost

D9933 Cleaning and inspection of removable complete denture, mandibular.....No Cost

D9934 Cleaning and inspection of removable partial denture, maxillary .....No Cost

D9935 Cleaning and inspection of removable partial denture, mandibular .....No Cost

D9986 Missed appointment
- *without 24 hour notice - per 15 minutes of appointment time*.....$10.00

D9987 Canceled appointment
- *without 24 hour notice - per 15 minutes of appointment time*.....$10.00

D9990 Certified translation or sign-language services - per visit .....No Cost

D9991 Dental case management - addressing appointment compliance barriers .....No Cost

D9992 Dental case management - care coordination .....No Cost

D9995 Teledentistry - synchronous; real-time encounter.....No Cost

D9996 Teledentistry - asynchronous; information stored and forwarded to dentist
for subsequent review .....No Cost

Optional is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are Benefits. "Filed fees" mean the Contract Dentist's fees on file with Alpha. Questions regarding this Program should be directed to the Customer Service department at 888-845-6023.

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialized Services, and are referred by the assigned Contract Dentist, must be authorized by Alpha. The Enrollee pays the Copayment specified for such services.

The Contract Dentist will provide Emergency Dental Services for covered procedures whenever possible. If an Enrollee requires Emergency Dental Services and is unable to access care from the Contract Dentist, then Alpha shall reimburse the Enrollee for the cost of such Emergency Dental Services which exceeds the Copayment. Emergency Dental Services shall be limited to listed procedures, and as described in code D9110 above: (Palliative (emergency) treatment of dental pain). Any further treatment of the cause of such Emergency Dental Services must be obtained from the Contract Dentist. All services are subject to the limitations and exclusions of the Program. Non-network Dentists will be paid at the usual and customary or an agreed upon rate.

FOOTNOTES

[1] *Services include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee, not to exceed $75.00 per month.*

[2] *Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.*

[3] *Porcelain on molars is considered optional treatment.*

[4] *Base or noble metal is the Benefit if the Contract Dentist determines that it will restore the form and function of the tooth. High noble metal (precious), if elected by the Enrollee for a crown, bridge, indirectly fabricated post and core, inlay or onlay, will be charged to the Enrollee at the additional laboratory cost of the high noble metal. An additional laboratory charge also applies to a titanium crown.*

[5] *Includes any adjustments for six months.*

SCHEDULE B

Limitations of Benefits

** Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.*

1. Prophylaxis is limited to one treatment each six month* period (includes periodontal maintenance).

2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five-year period from initial placement.

3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.

4. Crowns and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement.

5. Denture relines are limited to one per denture during any 12 consecutive months.

6. Periodontal treatments (scaling and root planing) are limited to four quadrants during any 12 consecutive months.

7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period.

8. Bitewing x-rays are limited to not more than one series of four films in any six month* period.

9. A full mouth x-ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months*.

10. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement.

11. Coverage is limited to the Benefit customarily provided. Enrollee must pay the difference in cost between the Contract Dentist's usual fees for the covered Benefit and the Optional or more expensive treatment plus any applicable Copayment.

12. Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures, such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial denture to restore a missing tooth, are considered Optional treatment.

13. Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to cuspid) and facial surfaces of maxillary bicuspids.

14. A fixed partial denture (bridge) is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, non-functional bridge and it meets the five year limitation for replacement.

15. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth.

16. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

17. Porcelain crowns and porcelain fused to metal crowns on all molars is considered Optional treatment.

18. Fixed bridges used to replace missing posterior teeth are considered Optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered Optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered procedure and Optional treatment, plus any Copayment for the covered procedure.

19. Benefits for dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with this Program are limited as follows:

Upon request of a newly covered Enrollee, Alpha will provide Benefits for the completion of covered services begun prior to the time his or her coverage became effective. Alpha will not provide coverage for incomplete services that are not otherwise Benefits under the terms and conditions of the Contract. Enrollees may request completion of treatment in progress by calling the Customer Service department at 888-845-6023 during normal business hours, or by sending a written request to Alpha.

Whenever possible, an Enrollee should complete treatment in progress with the Dentist who initiated the service. If such Dentist is an out-of-network Dentist, that Dentist must agree to the same terms and conditions that apply to an in-network Dentist in order for Alpha to provide Benefits. Copayments and other cost sharing components will apply. Benefits may be adjusted so that the total paid by the Enrollee and/or coverage provided by all plans is not more than 100% of total Allowable Expenses (as defined in the Coordination of Benefits section of the Contract).

Should the Enrollee be unable to complete treatment with the Dentist who initiated the service, Alpha will make reasonable and appropriate arrangements for completion of such treatment by a Contract Dentist.

SCHEDULE C

Exclusions of Benefits

1. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist.

2. Dental procedures performed for purely cosmetic purposes.

3. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is payable. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision.

4. Treatment required by reason of war, declared or undeclared.

5. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

6. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities.

7. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).

8. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

9. Any service that is not specifically listed in *Schedule A, Description of Benefits and Copayments*.

10. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function (unless mandated by state law).

11. Cysts and malignancies.

12. Prescription drugs.

13. Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.

14. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized by Alpha or as cited under *Emergency Dental Services.* To obtain Authorization, the Enrollee should call the Customer Service department at 888-845-6023.

15. Prophylactic removal of impactions (asymptomatic, nonpathological).

16. "Consultations" for noncovered procedures.

17. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.

18. Placement of a crown where there is sufficient tooth structure to retain a standard filling.

19. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

20. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ).

21. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction).

22. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization.

23. Any part of a preventive or soft tissue management program, which is not a listed covered service on *Schedule A, Description of Benefits and Copayments*.

24. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services;

25. Cosmetic care as a result of orthodontic treatment.

26. Extractions solely for the purpose of orthodontics.

27. Charges by the Contract Dentist for broken or missed appointments not reported within 24 hours.

28. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.

29. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

SCHEDULE D

Orthodontic Limitations

The Program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The cost to the Enrollee for the treatment plan is listed in *Schedule A, Description of Benefits and Copayments* subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist.

2. Benefits cover 24 months of active orthodontic treatment and include the initial examination, diagnosis, consultation, initial banding, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months.

3. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee not to exceed $75.00 per month.

4. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination. In this event the Enrollee's obligation shall be based on the Contract Orthodontist's usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of $25.00 in addition to diagnostic record fees.

6. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist's usual fee.

7. The Copayment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, (i) the Enrollee will not be entitled to a refund of any amounts

previously paid, and (ii) the Enrollee will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

SCHEDULE E

Orthodontic Exclusions

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.

2. Retreatment of orthodontic cases.

3. Changes in treatment necessitated by accident of any kind, and/or lack of Enrollee cooperation.

4. Surgical procedures incidental to orthodontic treatment.

5. Myofunctional therapy.

6. Surgical procedures related to cleft palate, micrognathia or macrognathia.

7. Treatment related to temporomandibular joint disturbances.

8. Supplemental appliances not routinely utilized in typical comprehensive orthodontics, including, but not limited to: palatal expander, habit control appliance, pendulum, quad helix or herbst.

9. Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed $75.00 per month.

10. Cosmetic care as a result of orthodontic treatment.

11. Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

12. Extractions solely for the purpose of orthodontics.

13. Patient initiated transfer after bands have been placed.

14. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

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