reliancestandard
LIFE INSURANCE COMPANY

Home Office: Schaumburg, Illinois Administrative Office: Philadelphia, Pennsylvania

GROUP DENTAL INSURANCE POLICY

The Policyholder	**PATHWAYS HOME HEALTH AND HOSPICE**		
		Policy Number	**136-422723**
State of Delivery	**California**	**Plan Effective Date**	**July 1, 2026**
Premium Due Date 1st of each month.		**Renewal Date**	**July 1**

Reliance Standard Life Insurance Company agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

RELIANCE STANDARD LIFE INSURANCE COMPANY

Secretary

President and Chief Executive Officer, Group Benefits

CALIFORNIA - IMPORTANT INFORMATION

We are here to serve you . . .

Your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. In the event you need to contact someone about this insurance coverage for any reason, including your ability to access dental services in a timely manner, please contact your agent or feel free to contact us at the following:

Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
1-877-897-4328 (Toll-Free)

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. If additional information is needed we will only request what is reasonably necessary to handle the claim. A written decision based on the facts as known by us will be provided within fifteen (15) calendar days after receipt of your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental practice.

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1 800 927 HELP (4357) or (213) 897-8921
TDD Number: 1-800-482-4TDD (4833)
The Hotline hours are from 8:00 a.m. - 6:00 p.m.
Mon - Fri (Except Holidays)
http://www.insurance.ca.gov

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows:

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323)782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800)927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

Thank you for choosing Reliance Standard for your dental care coverage. As a member, you always have complete freedom of choice in choosing your dental provider; however, by choosing a PPO network provider, you may reduce your out-of-pocket expenses due to the discounted fees on covered dental procedures.

Please read the following information so you will know from whom or what group of providers dental care may be obtained.

For the most current and complete provider listing and information, please visit the our website at **www.reliancematrix.com** and click on the ***Dental-Vision eServices*** link. Locate and click on ***Member Services*** and then choose ***Find a Provider***. Additional information available online includes driving directions to the provider's office and how to nominate a dentist or specialist for our network

If you do not have access to the Internet and are in need of dental participating provider information, contact our provider relations department at 1-800-755-8844.

For questions regarding your dental benefit coverage, contact our customer relations department at 1-800-497-7044 Monday - Thursday 7:00am - midnight and Friday, 7:00am - 6:30pm Central Time.

When scheduling your appointment, please verify the provider is an active network participant.

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or **877-233-3797**. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 877-233-3797. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Անվճար թարգմանչական ծառայություններ: Դուք կարող եք օգտվել թարգմանչի ծառայություններից, և ձեր փաստաթղթերը ձեզ համար կընթերցեն ձեր լեզվով: Եթե օգնության կարիք ունեք, զանգահարեք մեզ՝ ձեր նույնականացման (ID) քարտի վրա նշված հեռախոսահամարով կամ 877-233-3797 հեռախոսահամարով: Եթե լրացուցիչ օգնության կարիք ունենաք, զանգահարեք Կալիֆորնիա նահանգի Ապահովագրության վարչություն՝ (Department of Insurance) 1-800-927-4357 հեռախոսահամարով: Armenian

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打877-233-3797與我們聯絡。欲取得其他協助，請致電1-800-927-4357與加州保險部聯絡。Chinese

निशुल्क भाषा सेवाएँ। आप एक अनुवादक की सेवाएँ लेकर दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए हमें अपने आईडी कार्ड पर दिए नंबर या **877-233-3797** पर फोन करें। अधिक मदद के लिए CA Dept. of Insurance को 1-800-927-4357 Hindi

Cov Kev Pab Txais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 877-233-3797. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

無料の言語サービス　日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または877-233-3797までお問い合わせください。更なるお問い合わせは、カリフォニア州保険庁、1-800-927-4357までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 877-233-3797 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 적혀 있는 안내 전화로 문의해 주시 길 바랍니다: 887-233-3797. 더 자세한 사항을 문의하실 분들은 캘리포니아 주 보험국으로 연락해주시 길 바랍니다: 1-800-927-4357. Korean

خدمات رایگان ترجمه. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، از با شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 877-233-3797 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تماس حاصل نمایید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਿਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 877-233-3797 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные языковые услуги. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, пожалуйста, позвоните нам по номеру, указанному на вашей идентификационной карте, или наберите 877-233-3797. Если вам нужна дополнительная помощь, пожалуйста, обратитесь в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para recibir ayuda, llámenos al número que figura en su tarjeta de identificación o al **877-233-3797**. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

Walang Gastos na mga Serbisyo sa Wika. Maaari kayong kumuha ng isang interpreter o tagapagsalin at inyong ipabasa sa Tagalog ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa **877-233-3797**. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

บริการทางภาษาแบบไม่มีค่าใช้จ่าย คุณสามารถได้รับบริการจากล่ามและช่วยอ่านเอกสารในภาษาของคุณได้ หากต้องการความช่วยเหลือสามารถติดต่อได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือ **877-233-3797** สำหรับความช่วยเหลือเพิ่มเติมสามารถติดต่อได้ที่กรมการประกันภัยแห่งแคลิฟอร์เนีย (CA Dept. of Insurance) หมายเลข 1-800-927-4357 Thai

Các Dịch vụ Trợ giúp Ngôn ngữ Miễn phí. Quý vị có thể nhờ một thông dịch viên đọc các tài liệu cho quý vị nghe bằng ngôn ngữ của quý vị. Để được giúp đỡ, hãy gọi cho chúng tôi theo số điện thoại được ghi trên thẻ hội viên của quý vị hoặc gọi số **877-233-3797**. Để được trợ giúp thêm, xin gọi cho Sở Bảo hiểm Tiểu bang California theo số 1-800-927-4357. Vietnamese

California

Language Assistance/Non-Discrimination/Services for the Hearing Impaired/How to File a Complaint

Language Assistance
Reliance Standard Life Insurance Company language assistance program is designed to help Limited English Proficient (LEP) members with their language needs. It includes, but is not limited to, accessing an interpreter. A qualified interpreter will be provided at no cost to you by calling 877-233-3797. Information on how to access an interpreter is available in the top 15 languages spoken by Limited-English-Proficient individuals in California as determined by the State Department of Health Care Services.

Services for the Hearing Impaired
If you have a disability and require use of a Telecommunications Device for the Deaf (TDD), please dial 7-1-1 to use this free service. If you require additional service, contact Reliance Standard Life Insurance Company between 7:00 a.m. – 12:00 a.m. (CST) Monday through Thursday, and 7:00 a.m. - 6:30 p.m. (CST) Friday by calling the number on your ID card or 800-487-5553.

Non-Discrimination Policy
Reliance Standard Life Insurance Company complies with applicable Federal and State civil rights laws. Reliance Standard Life Insurance Company does not unlawfully discriminate, exclude people or treat them differently on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation in connection with the group dental and vision care insurance benefits provided to customers.

How to file a complaint
If you believe that Reliance Standard Life Insurance Company has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you may file a grievance with Reliance Standard Life Insurance Company at:

Reliance Standard Life Insurance Company
Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
1- 877-897-4328 (Toll-Free)

You may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance. To contact the Department, write or call:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357) or (213) 897-8921
TDD Number: 1-800-482-4TDD (4833)
The Hotline hours are from 8:00 a.m. - 6:00 p.m.
Mon - Fri (Except Holidays)
http://www.insurance.ca.gov

You may also file a discrimination complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You can file electronically through the Office for Civil Rights Complaint Portal (https://ocrportal.hhs.gov/ocr/portal/lobby.jsf) or you can file by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	Eligible Full-time Employee Electing The Ppo Dental Plan
Class 2	Eligible Full-time Employee Electing The Liberty Dental Plan
Class 3	Eligible Part-time Employee Electing The Ppo Dental Plan
Class 4	Eligible Part-time Employee Electing The Liberty Dental Plan

Class Number 1

IMPORTANT: If you opt to receive dental services that are not covered services under this policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 1-800-497-7044 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period.

Maximum Family Deductible	$150

Dental expenses incurred by an individual on or after January 1, 2026, but before July 1, 2026, will apply to the Deductible Amount if:

a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to July 1, 2026; and

b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.

Coinsurance Percentage:	
Type 1 Procedures	100%
Type 2 Procedures	80%
Type 3 Procedures	50%

Maximum Amount - Each Benefit Period	$1,500

Benefits for Dental Emergencies: If you are in need of emergency dental services and are unable to obtain such services from a Participating Provider, we will review and pay the eligible claims submitted as if you had visited a Participating Provider.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on June 30, 2026, and
b. on July 1, 2026 is both:

   i. insured under the policy, and

   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

Class Number 3

IMPORTANT: If you opt to receive dental services that are not covered services under this policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 1-800-497-7044 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period.

Maximum Family Deductible	$150

Dental expenses incurred by an individual on or after January 1, 2026, but before July 1, 2026, will apply to the Deductible Amount if:

a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to July 1, 2026; and

b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.

Coinsurance Percentage:	
Type 1 Procedures	100%
Type 2 Procedures	80%
Type 3 Procedures	50%
Maximum Amount - Each Benefit Period	$1,500

Benefits for Dental Emergencies: If you are in need of emergency dental services and are unable to obtain such services from a Participating Provider, we will review and pay the eligible claims submitted as if you had visited a Participating Provider.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on June 30, 2026, and

b. on July 1, 2026 is both:

   i. insured under the policy, and

   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Classes 01,03

Dental Care Insurance	$53.17 per Insured Person
	$47.72 One Dependent Only
	$119.22 Two or More Dependents

Classes 02,04

Dental Care Insurance	$13.84 per Insured Person
	$11.08 One Dependent Only
	$22.16 Two or More Dependents

Classes 01,03

Orthodontic Insurance	$1.40 per Insured Person
	$2.56 One Dependent Only
	$11.76 Two or More Dependents

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums (premium for the period which claims were not paid) to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 45 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, We the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of any one or more of the following:

1. The average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. The number of Insureds is less than 80% of those Insureds initially enrolled under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date; and/or

3. For policies with a multi-year rate guarantee, after the initial year, if we are required by any federal, state, or local regulation to change benefits as a result of regulatory change or pay a new or increased tax, assessment, related to the type of insurance offered under this policy.

Should any of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 45 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

COMPANY refers to Reliance Standard Life Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 1700 Market Street, Suite 1200, Philadelphia, PA 19103.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

REGISTERED DOMESTIC PARTNER means a partner of the Insured as long as the partnership meets the requirements for such relationship as defined in Section 297 of the California Family Code or the functional equivalent registration of any other state or local jurisdiction.

Pursuant to Sections 381.5 and 10121.7 of the California Insurance Code, coverage shall be provided to Registered Domestic Partners that is equal to, and subject to the same terms and conditions as, the coverage provided to a spouse.

UN-REGISTERED DOMESTIC PARTNER: Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another. This partnership has not been registered with the California Secretary of State as prescribed under Section 297 of the California Family Code or any other state or local jurisdiction.

CHILD. Child refers to the child of the Insured, a child of the Insured's spouse, a child of the Insured's Registered Domestic Partner, or a child of the Insured's Un-Registered Domestic Partner, if they otherwise meet the definition of Dependent.

Class Number 1

DEPENDENT refers to:

a. an Insured's spouse or an Insured's Registered Domestic Partner or an Un-Registered Domestic Partner.

b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse or the Insured's Registered Domestic Partner or the Insured's Un-Registered Domestic Partner, is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.

c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Injury or Sickness for Certain Dependents

Coverage will continue for a covered Dependent student if the student is unable to remain enrolled in school and must take a medically necessary leave of absence. Coverage will continue for a period not to exceed 24 months or the date on which coverage would otherwise terminate in accordance with the terms and provisions of the group policy, whichever comes first. We may require documentation and certification by the student's treating physician of the medical necessity of a leave of absence.

Class Number 3

DEPENDENT refers to:

a. an Insured's spouse or an Insured's Registered Domestic Partner or an Un-Registered Domestic Partner.

b. each unmarried and married child less than 26 years of age, for whom the Insured, the Insured's spouse or the Insured's Registered Domestic Partner or the Insured's Un-Registered Domestic Partner, is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws. Grandchildren, spouses of Dependents and other Dependent family members under the age of 26 are not eligible for coverage under this plan.

c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Injury or Sickness for Certain Dependents
Coverage will continue for a covered Dependent student if the student is unable to remain enrolled in school and must take a medically necessary leave of absence. Coverage will continue for a period not to exceed 24 months or the date on which coverage would otherwise terminate in accordance with the terms and provisions of the group policy, whichever comes first. We may require documentation and certification by the student's treating physician of the medical necessity of a leave of absence.

All Classes

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a “Network Provider”. The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider’s

contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred to as an "Out-of-Network Provider." Members are required to pay the difference between the plan payment and the provider's actual fee for covered services, and may also be subject to higher deductibles and out-of-pocket maximums. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

TELEHEALTH SERVICE refers to a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

Class Number 1

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible full-time employee electing the ppo dental plan working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Retirees are included in the Eligible Class for Insurance as defined by the Policyholder.

Prn (per-diem) Staff Employees are excluded from the Eligible Class for Insurance.

Employees who are enrolled in the Prepaid Plan are not members of the Eligible Class for Personal Insurance and are excluded from the coverage under this policy.

ANNUAL ENROLLMENT SWITCH PERIOD Any employee above who has been covered by the Prepaid Plan for six (6) months or more may become a Member under this policy at any Annual Enrollment Switch period. A thirty-one (31) day Annual Enrollment Switch period will be held each June to be effective July 1.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible full-time employee electing the ppo dental plan working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Retirees are included in the Eligible Class for Dependent Insurance as defined by the Policyholder.

Prn (per-diem) Staff Employees are excluded from the Eligible Class for Dependent Insurance.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This plan is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on July 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 30 calendar day(s) of continuous active employment.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

Class Number 3

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible part-time employee electing the ppo dental plan working at least 30 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Prn (per-diem) Staff Employees are excluded from the Eligible Class for Insurance.

Employees who are enrolled in the Prepaid Plan are not members of the Eligible Class for Personal Insurance and are excluded from the coverage under this policy.

ANNUAL ENROLLMENT SWITCH PERIOD Any employee above who has been covered by the Prepaid Plan for six (6) months or more may become a Member under this policy at any Annual Enrollment Switch period. A thirty-one (31) day Annual Enrollment Switch period will be held each June to be effective July 1.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible part-time employee electing the ppo dental plan working at least 30 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Prn (per-diem) Staff Employees are excluded from the Eligible Class for Dependent Insurance.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This plan is provided as part of the Employer's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this plan.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this plan at that time will have their coverage become effective on July 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 30 calendar day(s) of continuous active employment.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

<u>All Classes</u>

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

a. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

b. the person is considered a Member or an eligible Dependent under the policy providing this coverage, and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent under the prior policy.

TERMINATION DATES

Class Number 1

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. in the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums, subject to the Grace Period; or
3. the date of the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 3

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. in the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums, subject to the Grace Period; or
3. the date of the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

All Classes

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

Labor Dispute
For Employees Only

If membership is because of employment and the Insured's active service stops because of a labor dispute, the insurance may be continued subject to the following rules:

1. This provision only applies when the Policyholder is required by a collective bargaining agreement to pay all or part of the Insured's premiums.

2. The premium due for each Insured subject to this provision and the Insured's dependents, if applicable, will be that shown in the policy.

3. Payment of the premium by the Insured must be to the Policyholder, union, or other collection entity and forwarded to us on a monthly basis.

The insurance continued during such labor dispute will stop on the earliest of the following dates:

1. the date six months from the date cessation of work due to the labor dispute started.
2. the date that 75% of the Insureds subject to the labor dispute are continuing the coverage.
3. for any individual Insured:

    i. the date he or she takes full-time employment with another employer.
    ii. the last day of the period for which the Insured has made a premium payment.

Neither the Policyholder or us may cancel or alter the terms of the policy during the labor dispute, except that we can adjust premiums the same as we could if there were no labor dispute.

Any continuation of an Insured's benefits under this provision is applicable to the Insured's dependents, provided they were insured under the policy when the labor dispute started.

Class 1

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as covered under your plan, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC").

Usual and Customary (“U&C”) describes those dental charges which are the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from Ingenix which is a national organization which provides benchmarking services to the health care industry. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider’s fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

You and your dependents have the freedom to select any dentist of your choice nationwide. Out-of-pocket expenses may be lower if services are provided by a Participating Provider.

ACCESS TO PARTICIPATING PROVIDERS. If you are unable to schedule a visit with a Participating Provider within a reasonable period of time or driving distance and are not otherwise in need of emergency

services, please contact us at the toll-free number shown on your ID card and we will attempt to locate a Participating Provider for you to visit. However, if we are unable to locate a Provider for you or you are in need of emergency services and are unable to obtain such services from a Participating Provider, we will review and pay the eligible claims submitted as if you had visited a Participating Provider.

Provider Directories can be accessed by visiting our website www.reliancematrix.com.

For your convenience, our online directories are updated daily.

TIMELY ACCESS TO CARE.
Urgent appointments will be offered within seventy-two (72) hours of the time of request for appointment, when consistent with the Covered Person's individual needs and as required by professionally recognized standards of practice.

Non-urgent appointments will be offered within thirty-six (36) business days of the request for appointment. Preventive appointments will be offered within forty (40) business days of the request for appointment.

When it is necessary for a Dentist or a Covered Person to reschedule an appointment, Dentists will promptly reschedule in a manner that is appropriate for the Covered Person's health care needs, and ensures continuity of care consistent with good professional practice.

LANGUAGE INTERPRETER SERVICES. Language interpreter services are available at no cost to you, including at time of appointment by contacting us toll-free at 1-877-233-3797.

DENTAL EMERGENCY. Emergency health care services means health care services rendered for any condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy, (2) Serious impairment to bodily functions, (3) Serious dysfunction of any bodily organ or part.

URGENT CARE. Urgent care means a condition that requires prompt attention where the insured faces an imminent and serious threat to his or her health. This includes but is not limited to, the potential loss of life, limb, or other major bodily function, or when the normal timeframe for the decision making process would be detrimental to the insured's life or health or could jeopardize the insured's ability to regain maximum function.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for appliances, restorations, or procedures to:

   a. alter vertical dimension;
   b. restore or maintain occlusion; or
   c. splint or replace tooth structure lost as a result of abrasion or attrition.

2. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

3. to replace lost or stolen appliances.

4. for any treatment which is for cosmetic purposes.

5. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

6. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

7. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

8. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

9. because of war or any act of war, declared or not.

Class 3

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as covered under your plan, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC").

Usual and Customary ("U&C") describes those dental charges which are the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from Ingenix which is a national organization which provides benchmarking services to the health care industry. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

You and your dependents have the freedom to select any dentist of your choice nationwide. Out-of-pocket expenses may be lower if services are provided by a Participating Provider.

ACCESS TO PARTICIPATING PROVIDERS. If you are unable to schedule a visit with a Participating Provider within a reasonable period of time or driving distance and are not otherwise in need of emergency services, please contact us at the toll-free number shown on your ID card and we will attempt to locate a Participating Provider for you to visit. However, if we are unable to locate a Provider for you or you are in need of emergency services and are unable to obtain such services from a Participating Provider, we will review and pay the eligible claims submitted as if you had visited a Participating Provider.

Provider Directories can be accessed by visiting our website www.reliancematrix.com.

For your convenience, our online directories are updated daily.

TIMELY ACCESS TO CARE.
Urgent appointments will be offered within seventy-two (72) hours of the time of request for appointment, when consistent with the Covered Person's individual needs and as required by professionally recognized standards of practice.

Non-urgent appointments will be offered within thirty-six (36) business days of the request for appointment. Preventive appointments will be offered within forty (40) business days of the request for appointment.

When it is necessary for a Dentist or a Covered Person to reschedule an appointment, Dentists will promptly reschedule in a manner that is appropriate for the Covered Person's health care needs, and ensures continuity of care consistent with good professional practice.

LANGUAGE INTERPRETER SERVICES. Language interpreter services are available at no cost to you, including at time of appointment by contacting us toll-free at 1-877-233-3797.

DENTAL EMERGENCY. Emergency health care services means health care services rendered for any condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy, (2) Serious impairment to bodily functions, (3) Serious dysfunction of any bodily organ or part.

URGENT CARE. Urgent care means a condition that requires prompt attention where the insured faces an imminent and serious threat to his or her health. This includes but is not limited to, the potential loss of life, limb, or other major bodily function, or when the normal timeframe for the decision making process would be detrimental to the insured's life or health or could jeopardize the insured's ability to regain maximum function.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

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1. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

2. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

3. to replace lost or stolen appliances.

4. for any treatment which is for cosmetic purposes.

5. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

6. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

7. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

8. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

9. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section. **No benefits are payable for a procedure that is not listed.**

Class Number 1

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 3

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

All Classes

- Covered procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- Radiographic images, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

Class Number 1, 3

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
D0150 Comprehensive oral evaluation - new or established patient.
D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

Coverage is limited to 1 of each of these procedures per provider.
In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per benefit period.
D0120, D0145, also contribute(s) to this limitation.
If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

Coverage is limited to 2 of any of these procedures per benefit period.
D0150, D0180, also contribute(s) to this limitation.
Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - comprehensive series of radiographic images.
D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.
D0230 Intraoral - periapical each additional radiographic image.
D0240 Intraoral - occlusal radiographic image.
D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.
D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS

D0270 Bitewing - single radiographic image.
D0272 Bitewings - two radiographic images.
D0273 Bitewings - three radiographic images.
D0274 Bitewings - four radiographic images.
D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

Coverage is limited to 1 of any of these procedures per benefit period.
D0277, also contribute(s) to this limitation.
The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

Coverage is limited to 1 of any of these procedures per 3 year(s).
The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.

TYPE 1 PROCEDURES

D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
D9932 Cleaning and inspection of removable complete denture, maxillary.
D9933 Cleaning and inspection of removable complete denture, mandibular.
D9934 Cleaning and inspection of removable partial denture, maxillary.
D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

Coverage is limited to 2 of any of these procedures per benefit period.
Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

Coverage is limited to 2 of any of these procedures per benefit period.
D4346, D4910, also contribute(s) to this limitation.
An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935

Coverage is limited to 2 of any of these procedures per benefit period.
Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

SEALANTS AND CARIES MEDICAMENTS

D1351 Sealant - per tooth.
D1353 Sealant repair - per tooth.
D1354 Application of caries arresting medicament-per tooth.
D1355 Caries preventive medicament application - per tooth.

SEALANT: D1351, D1353

Coverage is limited to 1 of any of these procedures per 3 year(s).
D1354, D1355, also contribute(s) to this limitation.
Benefits are considered for persons age 15 and under.
Benefits are considered on permanent molars only.
Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510 Space maintainer-fixed, unilateral-per quadrant.
D1516 Space maintainer - fixed - bilateral, maxillary.
D1517 Space maintainer - fixed - bilateral, mandibular.
D1520 Space maintainer-removable, unilateral-per quadrant.
D1526 Space maintainer - removable - bilateral, maxillary.
D1527 Space maintainer - removable - bilateral, mandibular.
D1551 Re-cement or re-bond bilateral space maintainer-maxillary.
D1552 Re-cement or re-bond bilateral space maintainer-mandibular.
D1553 Re-cement or re-bond unilateral space maintainer-per quadrant.
D1556 Removal of fixed unilateral space maintainer-per quadrant.
D1557 Removal of fixed bilateral space maintainer-maxillary.
D1558 Removal of fixed bilateral space maintainer-mandibular.
D1575 Distal shoe space maintainer - fixed, unilateral-per quadrant.

SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527, D1575

Benefits are considered for persons age 18 and under.
Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION
- D0140 Limited oral evaluation - problem focused.
- D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY
- D0472 Accession of tissue, gross examination, preparation and transmission of written report.
- D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
- D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

Coverage is limited to 1 of any of these procedures per 12 month(s).

Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)
- D2140 Amalgam - one surface, primary or permanent.
- D2150 Amalgam - two surfaces, primary or permanent.
- D2160 Amalgam - three surfaces, primary or permanent.
- D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)
- D2330 Resin-based composite - one surface, anterior.
- D2331 Resin-based composite - two surfaces, anterior.
- D2332 Resin-based composite - three surfaces, anterior.
- D2335 Resin-based composite - four or more surfaces (anterior).
- D2391 Resin-based composite - one surface, posterior.
- D2392 Resin-based composite - two surfaces, posterior.
- D2393 Resin-based composite - three surfaces, posterior.
- D2394 Resin-based composite - four or more surfaces, posterior.
- D2410 Gold foil - one surface.
- D2420 Gold foil - two surfaces.
- D2430 Gold foil - three surfaces.
- D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

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

STAINLESS STEEL CROWN (PREFABRICATED CROWN)
- D2390 Resin-based composite crown, anterior.
- D2928 Prefabricated porcelain/ceramic crown - permanent tooth.
- D2929 Prefabricated porcelain/ceramic crown - primary tooth.
- D2930 Prefabricated stainless steel crown - primary tooth.
- D2931 Prefabricated stainless steel crown - permanent tooth.

TYPE 2 PROCEDURES

D2932 Prefabricated resin crown.
D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2928, D2929, D2930, D2931, D2932, D2933, D2934

Replacement is limited to 1 of any of these procedures per 12 month(s).
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
D2920 Re-cement or re-bond crown.
D2921 Reattachment of tooth fragment, incisal edge or cusp.
D6092 Re-cement or re-bond implant/abutment supported crown.
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
D6930 Re-cement or re-bond fixed partial denture.

SEDATIVE FILLING

D2940 Placement of interim direct restoration.
D2991 Application of hydroxyapatite regeneration medicament - per tooth.

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal debridement, primary and permanent teeth.
D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
D3333 Internal root repair of perforation defects.
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, pulp space disinfection, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3357 Pulpal regeneration - completion of treatment.
D3430 Retrograde filling - per root.
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.
D3921 Decoronation or submergence of an erupted tooth.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920, D3921

Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Endodontic therapy, anterior tooth.
D3320 Endodontic therapy, premolar tooth (excluding final restorations).
D3330 Endodontic therapy, molar tooth (excluding final restorations).
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - premolar.
D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

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

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

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

TYPE 2 PROCEDURES

SURGICAL ENDODONTICS

- D3355 Pulpal regeneration - initial visit.
- D3356 Pulpal regeneration - interim medication replacement.
- D3410 Apicoectomy - anterior.
- D3421 Apicoectomy - premolar (first root).
- D3425 Apicoectomy - molar (first root).
- D3426 Apicoectomy (each additional root).
- D3471 Surgical repair of root resorption - anterior.
- D3472 Surgical repair of root resorption - premolar.
- D3473 Surgical repair of root resorption - molar.
- D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.
- D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.
- D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.

SURGICAL PERIODONTICS

- D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
- D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
- D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
- D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
- D4265 Biologic materials to aid in soft and osseous tissue regeneration, per site.
- D4270 Pedicle soft tissue graft procedure.
- D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
- D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
- D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
- D4276 Combined connective tissue and pedicle graft, per tooth.
- D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
- D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
- D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
- D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265

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

GINGIVECTOMY: D4210, D4211

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

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

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

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285

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

TYPE 2 PROCEDURES

NON-SURGICAL PERIODONTICS

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

ANTIMICROBIAL AGENTS: D4381

Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

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

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.

FULL MOUTH DEBRIDEMENT: D4355

Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.
D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4346, D4910

Coverage is limited to 2 of any of these procedures per benefit period.
D1110, D1120, also contribute(s) to this limitation.
Benefits are not available if performed on the same date as any other periodontal service.
Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.
Procedure D4346 is limited to persons age 14 and over.

DENTURE REPAIR

D5511 Repair broken complete denture base, mandibular.
D5512 Repair broken complete denture base, maxillary.
D5520 Replace missing or broken teeth - complete denture - per tooth.
D5611 Repair resin partial denture base, mandibular.
D5612 Repair resin partial denture base, maxillary.
D5621 Repair cast partial framework, mandibular.
D5622 Repair cast partial framework, maxillary.
D5630 Repair or replace broken retentive/clasping materials per tooth.
D5640 Replace missing or broken teeth - partial denture - per tooth.

NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - primary tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

SURGICAL EXTRACTIONS

D7210 Extraction, 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 Removal of residual tooth roots (cutting procedure).
D7251 Coronectomy - intentional partial tooth removal, impacted teeth only.
D7252 Partial extraction for immediate implant placement.

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).

TYPE 2 PROCEDURES

D7280 Exposure of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty 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 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
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.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
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.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7509 Marsupialization of odontogenic cyst.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7961 Buccal/labial frenectomy (frenulectomy).
D7962 Lingual frenectomy (frenulectomy).
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
D7286 Incisional biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection.
D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

D9110 Palliative treatment of dental pain - per visit.

PALLIATIVE TREATMENT: D9110

TYPE 2 PROCEDURES

Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.
D9222 Administration of deep sedation/general anesthesia - first 15 minute increment, or any portion thereof.
D9223 Administration of deep sedation/general anesthesia - each subsequent 15 minute increment, or any portion thereof.
D9224 Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof.
D9225 Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof.
D9239 Administration of moderate sedation - intravenous first 15 minute increment, or any portion thereof.
D9243 Administration of moderate sedation - intravenous - each subsequent 15 minute increment, or any portion thereof.

GENERAL ANESTHESIA: D9222, D9223, D9224, D9225, D9239, D9243

Coverage is only available with a cutting procedure. A maximum of four (D9222, D9223, D9224, D9225, D9239, D9243, D9246 or D9247) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
D9440 Office visit - after regularly scheduled hours.
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

Coverage is limited to 1 of any of these procedures per provider.

OFFICE VISIT: D9430, D9440

Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

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

ONLAY RESTORATIONS

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

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

Replacement is limited to 1 of any of these procedures per 5 year(s).
D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2753 Crown-porcelain fused to titanium and titanium alloys.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.

TYPE 3 PROCEDURES

D2790 Crown - full cast high noble metal.
D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium and titanium alloys.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months. Coverage is limited to necessary placement resulting from decay or traumatic injury.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

VENEERS

D2960 Labial veneer (resin laminate) - direct.
D2961 Labial veneer (resin laminate) - indirect.
D2962 Labial veneer (porcelain laminate) - indirect.

LABIAL VENEERS: D2960, D2961, D2962

Replacement is limited to 1 of any of these procedures per 5 year(s).

Frequency is waived for accidental injury.

Benefits are considered on anterior teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair necessitated by restorative material failure.
D2981 Inlay repair necessitated by restorative material failure.
D2982 Onlay repair necessitated by restorative material failure.
D2983 Veneer repair necessitated by restorative material failure.
D6980 Fixed partial denture repair necessitated by restorative material failure.
D9120 Fixed partial denture sectioning.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.

TYPE 3 PROCEDURES

D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5225 Maxillary partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
D5226 Mandibular partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
D5227 Immediate maxillary partial denture-flexible base (including any clasps, rests and teeth).
D5228 Immediate mandibular partial denture-flexible base(including any clasps, rests and teeth).
D5282 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
D5283 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth)-per quadrant.
D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth)-per quadrant.
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
D5821 Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular.
D5863 Overdenture - complete maxillary - natural tooth borne.
D5864 Overdenture - partial maxillary - natural tooth borne.
D5865 Overdenture - complete mandibular - natural tooth borne.
D5866 Overdenture - partial mandibular - natural tooth borne.
D5876 Add metal substructure to acrylic complete denture - per arch.
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D5876, D6110, D6111, D6114, D6115

Replacement is limited to 1 of any of these procedures per 5 year(s).
Frequency is waived for accidental injury.
Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5227, D5228, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

Replacement is limited to 1 of any of these procedures per 5 year(s).
D6010, D6040, D6050, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS
- D5410 Adjust complete denture - maxillary.
- D5411 Adjust complete denture - mandibular.
- D5421 Adjust partial denture - maxillary.
- D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422
Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL
- D5650 Add tooth to existing partial denture - per tooth.
- D5660 Add clasp to existing partial denture-per tooth.

DENTURE REBASES
- D5710 Rebase complete maxillary denture.
- D5711 Rebase complete mandibular denture.
- D5720 Rebase maxillary partial denture.
- D5721 Rebase mandibular partial denture.
- D5725 Rebase hybrid prosthesis.

DENTURE RELINES
- D5730 Reline complete maxillary denture (direct).
- D5731 Reline complete mandibular denture (direct).
- D5740 Reline maxillary partial denture (direct).
- D5741 Reline mandibular partial denture (direct).
- D5750 Reline complete maxillary denture (indirect).
- D5751 Reline complete mandibular denture (indirect).
- D5760 Reline maxillary partial denture (indirect).
- D5761 Reline mandibular partial denture (indirect).
- D5765 Soft liner for complete or partial removable denture-indirect.

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5765
Coverage is limited to service dates more than 6 months after placement date.

TISSUE CONDITIONING
- D5850 Tissue conditioning, maxillary.
- D5851 Tissue conditioning, mandibular.

IMPLANTS
- D6010 Surgical placement of implant body: endosteal implant.
- D6040 Surgical placement: eposteal implant.
- D6050 Surgical placement: transosteal implant.
- D6051 Placement of interim implant abutment.
- D6055 Connecting bar-implant supported or abutment supported.
- D6056 Prefabricated abutment - includes placement.
- D6057 Custom abutment - includes placement.
- D6191 Semi-precision abutment-placement.
- D6192 Semi-precision attachment-placement.

IMPLANT: D6010, D6040, D6050
Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284, D5286, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
Frequency is waived for accidental injury.

TYPE 3 PROCEDURES

Benefits for procedures D6051, D6055, D6056, D6057, D6191 and D6192 will be contingent upon the implant being covered. Replacement for procedures D6056, D6057, D6191 and D6192 are limited to 1 of any of these procedures in 5 years.

IMPLANT SERVICES

D6049 Scaling and debridement of a single implant with peri-implantitis, bleeding on probing, and deep pockets; includes implant surface cleaning without flap entry or closure.
D6080 Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments.
D6081 Scaling & debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing & increased pocket depths; includes cleaning of the implant surfaces.
D6089 Accessing and retorquing loose implant screw - per screw.
D6090 Repair of implant/abutment supported prosthesis.
D6091 Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment.
D6096 Remove broken implant retaining screw.
D6100 Surgical removal of implant body.
D6105 Removal of implant body not requiring bone removal nor flap elevation.
D6180 Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments.
D6190 Radiographic/surgical implant index, by report.
D6193 Replacement of an implant screw.
D6197 Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.
D6198 Remove interim implant component.

IMPLANT SERVICES: D6049, D6080, D6081, D6089, D6090, D6091, D6096, D6100, D6105, D6180, D6190, D6193, D6197, D6198

Coverage for D6049, D6080, D6081 and D6180 is limited to 2 of any of these procedures in a 12 month period. Coverage for D6089, D6090, D6091, D6096 and D6193 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported crown - porcelain fused to high noble alloys.
D6067 Implant supported crown - high noble alloys.
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.
D6077 Implant supported retainer for metal FPD - high noble alloy.
D6082 Implant supported crown-porcelain fused to predominantly base alloys.
D6083 Implant supported crown-porcelain fused to noble alloys.
D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
D6086 Implant supported crown-predominantly base alloys.
D6087 Implant supported crown-noble alloys.
D6088 Implant supported crown-titanium and titanium alloys.

TYPE 3 PROCEDURES

D6094 Abutment supported crown - titanium and titanium alloys.
D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
D6121 Implant supported retainer for metal FPD-predominantly base alloys.
D6122 Implant supported retainer for metal FPD-noble alloys.
D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium and titanium alloys.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6243 Pontic-porcelain fused to titanium and titanium alloys.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.
D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6784 Retainer crown 3/4-titanium and titanium alloys.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.

TYPE 3 PROCEDURES

D6794 Retainer crown - titanium and titanium alloys.
D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932. D2933 or D2934 has been performed within 12.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

TYPE 3 PROCEDURES

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

BONE AUGMENTATION

D6104 Bone graft at time of implant placement.
D6106 Guided tissue regeneration - resorbable barrier, per implant.
D6107 Guided tissue regeneration - non-resorbable barrier, per implant.
D7939 Indexing for osteotomy using dynamic robotic assisted or dynamic navigation.
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach.
D7952 Sinus augmentation via a vertical approach.
D7953 Bone replacement graft for ridge preservation - per site.
D7956 Guided tissue regeneration, edentulous area - resorbable barrier, per site.
D7957 Guided tissue regeneration, edentulous area - non-resorbable barrier, per site.

BONE AUGMENTATION: D6104, D6106, D6107, D7939, D7950, D7951, D7952, D7953, D7956, D7957

Each quadrant is limited to 1 of any of these procedures per 5 year(s).

Coverage of D6104, D6106, D6107, D7939, D7950, D7951, D7952, D7953, D7956 and D7957 is limited to the treatment and placement of endosteal implant D6010, D6040 eposteal implant or D6050 transosteal implant.

OCCLUSAL GUARD

D9944 Occlusal guard - hard appliance, full arch.
D9945 Occlusal guard - soft appliance, full arch.
D9946 Occlusal guard - hard appliance, partial arch.

OCCLUSAL GUARD: D9944, D9945, D9946

Coverage is limited to 1 of any of these procedures per 3 year(s).

Benefits will not be available if performed for athletic purposes.

ORTHODONTIC EXPENSE BENEFITS

Class Number 1

Orthodontic expense benefits will be determined according to the terms of the policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the bands, brackets or appliances are placed. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on June 30, 2026 and are both:

   a. insured under this policy; and
   b. currently undergoing a Treatment Program on July 1, 2026.

2. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.

3. if the Insured's insurance under this section terminates.

4. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

5. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

6. because of war or any act of war, declared or not.

7. To replace lost, missing or stolen orthodontic appliances.

Class Number 3

Orthodontic expense benefits will be determined according to the terms of the policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the bands, brackets or appliances are placed. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on June 30, 2026 and are both:

   a. insured under this policy; and
   b. currently undergoing a Treatment Program on July 1, 2026.

2. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.

3. if the Insured's insurance under this section terminates.

4. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

5. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

6. because of war or any act of war, declared or not.

7. To replace lost, missing or stolen orthodontic appliances.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has dental coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense.**

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(2) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The **Plan** covering the **Custodial parent**;

The **Plan** covering the spouse of the **Custodial parent**;

The **Plan** covering the **non-custodial parent**; and then

The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided by a Participating Provider and within 180 days after the incurred date of the services provided by a Non-Participating Provider. If it is impossible to give written proof within the required time period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

NOTICE REQUIREMENTS. If an Insured's coverage under this policy is terminated, premiums are increased, benefits are reduced or eliminated or eligibility for such coverage is restricted in any way, then such action will not be effective unless written notice of the action is delivered by mail to the last known address of the appropriate insurance producer and the administrator, if any, at least 45 days prior to the effective date of the action and to the last known address of the Employer Unit and the certificate holder at least 30 days prior to the effective date of the action.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

TELEHEALTH SERVICES

All services under this plan are covered when appropriately delivered through telehealth services and are subject to the same deductible and annual or lifetime dollar maximum (if applicable) as for equivalent services that are not provided through telehealth.

GENERAL PROVISIONS (CONTINUED)

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to void the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Members must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	60%
Number of Members-	73

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Reliance Standard Life Insurance Company
P.O. Box 82510
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

Dental Utilization Review Program. Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.

g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:
Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Application is Hereby Made to

RELIANCE STANDARD LIFE INSURANCE COMPANY

by: PATHWAYS HOME HEALTH AND HOSPICE

whose main office address is: 585 N MARY AVE
SUNNYVALE, CA 94085-2905

for Group Policy No. 136-422723

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

PATHWAYS HOME HEALTH AND HOSPICE

(Full or Corporate Name of Applicant)

Dated at_____ By _____
(Signature and Title)

On _____, 20___ Witness_____
(To be signed by Resident Agent where required by law)

This copy is to remain Attached to the Policy

GROUP AGREEMENT

THIS GROUP AGREEMENT (the "Agreement") is made and entered into by and between **LIBERTY Dental Plan of California, Inc.** ("LIBERTY") and PATHWAYS HOME HEALTH AND HOSPICE ("Group") (each individually a "Party" and together, the "Parties"), effective as of the July 1, 2026 (the "Effective Date"). The benefit plan selected, described in Attachment A, is known as LDP-600 (Ortho 275)**.**

ARTICLE I
DEFINITIONS

1.1 **"Act"** means the Knox-Keene Health Care Service Plan Act of 1975, as amended.

1.2 "**Administrator"** means Reliance Standard Life Insurance Company (Reliance Standard) which is contracted with LIBERTY Dental Plan to perform certain administrative services with respect to this Agreement.

1.3 **"Benefits"** mean those dental care services available to a Member under the Plan in which such Member is enrolled pursuant to this Agreement.

1.4 **"Child"** means a natural, adopted, foster or step child.

1.5 **"Copayment"** means a specific fee that a Member is required to pay for a Covered Service and that is approved by the applicable state governmental authority and disclosed in the Member's Evidence of Coverage.

1.6 **"Covered Services"** mean those dental services and dental supplies that a Member is entitled to receive pursuant to the terms of the Member's Plan.

1.7 **"Dependent"** of a Subscriber means an individual who resides or works within the Service Area and who qualifies as one of the following:

(a) The lawful spouse or Domestic Partner of the Subscriber. A "Domestic Partner" is any person whose domestic partnership with the Subscriber is currently registered with a governmental body pursuant to state or local law, whether the Subscriber and Domestic Partner are a same-sex or an opposite-sex couple.

(b) The dependent Child of the Subscriber where the Child is:

(i) **For LIBERTY Plan Members:** under twenty-six (26) years old

(ii) twenty-six (26) years old or older if the Child can be certified by the Plan as incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and as chiefly dependent upon the Subscriber for support and maintenance. Subscriber must provide proof of such incapacity and dependence to LIBERTY within thirty-one (31) days of LIBERTY's request. LIBERTY may require recertification of such incapacity (but not more frequently than once annually) after the two-year (2-year) period following the dependent's attainment of age twenty-six (26).

A newborn Child shall be covered from the moment of his/her birth if the Child is enrolled in the Plan. A minor adopted Child shall be covered from the time he/she is placed in custody of the adoptive Subscriber if the Child is enrolled in the Plan.

1.8 **"Evidence of Coverage"** means the certificate, agreement, contract, brochure or letter of entitlement issued to a Subscriber or Member setting forth the Benefits and terms of the Plan in which the Subscriber/Member is enrolled. LIBERTY shall provide the Evidence of Coverage, as well as any amended or updated versions of the Evidence of Coverage, to Group for Group's delivery to Members.

1.9 **"Exclusion"** means a specified service, supply or condition that is entirely eliminated from coverage under the Plan.

1.10 **"Grace Period"** means a period of at least 30 consecutive days after the date specified in LIBERTY's notice of the start of the Grace Period, which date shall be no earlier than the day after the last date of paid coverage.

1.11 **"Grievance"** means a written or oral expression of dissatisfaction regarding the Plan and/or a Plan Provider, including quality of care concerns.

1.12 **"Limitation"** means a restriction on the coverage for a specified service, supply or condition under the Plan.

1.13 **"Member"** means a Subscriber or Dependent who is eligible for enrollment in the Plan pursuant to Article II of this Agreement and is currently enrolled in the Plan.

1.14 **"Open Enrollment Period"** means the thirty-day (30-day) time period (or other length of time) that occurs every twelve (12) months after the Effective Date and that is mutually agreed upon by the Parties.

1.15 **"Plan"** means the LIBERTY dental benefits plan(s) offered by Group to its Members pursuant to this Agreement.

1.16 **"Plan Provider"** means a California-licensed dental services provider contracted by LIBERTY to render Covered Services to Members.

1.17 **"Premium"** means the amount Group must pay to LIBERTY on a monthly basis in order to offer Benefits to Members.

1.18 **"Service Area"** means the geographic region in which LIBERTY provides, or arranges for the provision of, dental services under this Agreement.

1.19 **"Subscriber"** means the individual whose employment, collective bargaining unit membership or other status (except for family dependency) serves as the basis for eligibility for enrollment in the Plan

ARTICLE II
ELIGIBILITY AND ENROLLMENT

2.1 **Eligibility.** To be eligible for enrollment in a Plan as a Subscriber, an individual must:

(a) be an active full-time employee of or collective bargaining unit member of the Group or must otherwise meet the eligibility requirements of the Group;

(b) not have been previously terminated under an individual or group insurance policy due to fraud or deception by the individual (or by another where the individual permitted such fraud or deception);

(c) reside or work within the Service Area; *and*

(d) meet all other applicable eligibility requirements of the Group.

2.2 Dependent Enrollment. An eligible Dependent may be enrolled in a Plan: (a) at the time Subscriber enrolls in such Plan; (b) within thirty (30) days of the Dependent first becoming eligible to enroll in the Plan in which Subscriber is enrolled; or (c) during the Open Enrollment Period.

2.3 Start and End of Member Coverage.

(a) *Start of Member Coverage.* A Member becomes eligible to receive Benefits at 12:01 am on the first (1st) day of the month following the month in which Member is listed as eligible on the eligibility listing submitted by Group pursuant to Section 2.4 below, unless other rules regarding the timing of coverage have been mutually agreed upon in writing by the Parties.

(b) *End of Member Coverage.* A Member's coverage shall terminate upon the earlier of the following:
- (i) Expiration or termination of this Agreement;
- (ii) The applicable Subscriber's termination or resignation from the Group;
- (iii) The end of the period for which the last Premium payment for the Member was remitted by Group;
- (iv) Member's entry into full-time military service;
- (v) The date on which the Member no longer resides or works in the Service Area;
- (vi) Member's attainment of the age of twenty-six (26) years old if the Member is a Dependent Child, unless the Member meets the requirements set forth in Section 1.6(b)(iv);
- (vii) LIBERTY's determination that the Member has committed fraud or deception with respect to the benefits and/or the Plan (or that the Member permitted another to commit such fraud or deception); or
- (viii) A determination that the Member is unable to establish and/or maintain a satisfactory dentist-patient relationship with any Plan Provider.

2.4 Group Submission of Eligibility Information. Group shall submit, securely and in accordance with applicable privacy and information security laws and regulations, Member eligibility lists to Reliance Standard on a monthly basis (or at such other frequency as mutually agreed upon in writing by the Parties) and in a format and manner mutually agreed upon in writing by the Parties.

(a) *Minimum Information to be Included in Eligibility Lists.* Such eligibility lists shall state any changes to the current listing of Members and identify the following data: (a) Members newly eligible to receive Benefits, (b) Members who are no longer eligible to receive Benefits, and (c) Members' social security numbers or other identification numbers and such other information as reasonably requested by LIBERTY.

(b) *Retroactive Eligibility.* The Parties acknowledge and agree that the effective date of Member eligibility additions and deletions shall not exceed ninety (90) days' retroactivity. Group shall pay Reliance Standard the Premium for such added or deleted Members strictly in accordance with the retroactive eligibility dates and with all other payment provisions set forth in this Agreement.

ARTICLE III
BENEFITS AND PREMIUMS

3.1 Benefits; Exclusions and Limitations; Emergency Dental Care. Members shall be entitled to receive those Benefits included in the applicable Plan set forth in Attachment A, subject to the Exclusions and Limitations (if any) and corresponding Copayments set forth in Attachment A. The Parties acknowledge and agree that LIBERTY has no, and shall not be deemed to have any, financial responsibility for services that are not covered under the applicable Plan.

(a) *Choice of Provider.* Only those dental services which are listed as Benefits under the applicable Plan and are rendered by a Plan Provider will be deemed Covered Services. In addition to the foregoing requirements, where the Plan requires Plan Provider assignment, services must be rendered by the Plan Provider to which the Member is specifically assigned in order for such services to be deemed Covered Services. Under such a Plan, a Member may change Plan Provider assignments by contacting LIBERTY and requesting such assignment change by the twentieth (20th) day of the month for the change to be effective as of the following month.

Notwithstanding any of the foregoing, LIBERTY may reassign Members to different Plan Providers at any time.

(b) *Emergency Dental Care.* In the event a Member requires Emergency Dental Care, as defined in the Member's then-current Evidence of Coverage, the Member shall follow the procedures outlined in his/her then-current Evidence of Coverage. To the extent the Emergency Dental Care requirements set forth in such Evidence of Coverage have been met, LIBERTY shall cover up to Seventy-Five Dollars ($75) of qualifying Emergency Dental Care services per calendar year, in accordance with the reimbursement procedures outlined in the Member's Evidence of Coverage.

(c) *Continuity of Care.* Members' rights to completion of care shall be governed by LIBERTY's then-current Continuity of Care Policy and applicable law.

3.2 Premiums.

(a) *Premium Payment.* Group shall pay monthly Premiums to Reliance Standard in accordance with the Premium rates set forth in Attachment B. Group shall pay all such Premiums due by the twentieth (20th) day of the month prior to the month of coverage. Unless the Parties have mutually agreed upon ACH/wire as the payment method (in which case, Group shall make such payments in accordance with Reliance Standard's instructions), Group shall remit such Premium payments in the form of a check or money order to:

Reliance Standard Life Insurance Company
PO Box 650804
Dallas, TX 75265-0804

(b) *Failure to Pay Premium.* The Parties acknowledge and agree that if Reliance Standard does not receive Premium payment in full by the end of the month in coverage, this Agreement and all coverage afforded the Group under it may be terminated by LIBERTY in accordance with Section 4.3(b). In addition, the Parties acknowledge and agree that Group shall pay a Thirty Dollar ($30) fee for each returned check.

3.3 Changes. LIBERTY may make changes to the Benefits, Copayments, and/or Premium rates at any time, provided that LIBERTY shall provide Group at least sixty (60) days' advance written notice of any reduction in Benefits or increase in Premium rates. Notwithstanding the foregoing, LIBERTY may pass through any additional fees or taxes imposed upon LIBERTY by a governmental agency or otherwise imposed upon LIBERTY by a change in applicable law or regulation, including but not limited to the Patient Protection and Affordable Care Act.

ARTICLE IV
TERM AND TERMINATION OF THIS AGREEMENT

4.1 Term. This Agreement shall commence on the Effective Date and continue for 1 (#) year(s).

4.2 Renewal. Upon expiration of the initial term of this Agreement, this Agreement shall automatically renew (unless either Party elects not to renew in accordance with this Section 4.2) upon the same terms and conditions, subject to any changes made by LIBERTY to the Benefits, Copayments, and/or Premium rates, for additional one-year (1-year) terms. LIBERTY shall provide written notice to Group of any changes to the Benefits, Copayments and/or Premium rates at least sixty (60) days prior to the end of the then-current term. LIBERTY may elect not to renew this Agreement by providing written notice to Group at least sixty (60) days prior to the end of the then-current term; Group may elect not to renew this Agreement by providing written notice to LIBERTY at least fifteen (15) days prior to the end of the then-current term.

4.3 Termination.

(a) *Termination for Breach.* If LIBERTY determines that Group has breached any material provision of this Agreement and Group fails to cure the breach to LIBERTY's satisfaction within fifteen (15) days following

LIBERTY's notice to Group specifying the nature of the breach, LIBERTY may terminate this Agreement; provided, however, that if the breach constitutes a terminable event under Section 4.3(b) or 4.3(c) below, LIBERTY may instead follow the termination procedures set forth in the applicable subsection.

(b) *Termination for Nonpayment.* If LIBERTY does not receive Premium payment in full by the end of the 30 day grace period, following the current month of coverage, LIBERTY may terminate this Agreement and all coverage afforded the Group under it, such termination to be effective as of the last day of the month of coverage, following the Grace Period.

(c) *Immediate Termination.* LIBERTY may immediately terminate this Agreement upon: (i) the institution by or against Group of insolvency, receivership or bankruptcy proceedings or any other proceedings for the settlement of Group's debts; (ii) Group making an assignment for the benefit of creditors; (iii) Group's dissolution or ceasing to do business; (iv) a reduction in Group's membership to less than two (2) Members.

(d) Notification Requirements. In accordance with Section 4.3 of this Agreement, notification that this Agreement is being terminated by LIBERTY will be sent to the Group in writing. The Group will be responsible for promptly sending such notice to each subscriber enrolled in the Plan in accordance with the terms of the Evidence of Coverage.

ARTICLE V
GRIEVANCES

5.1 Grievance Procedures. If a Member has a Grievance, the Member shall contact LIBERTY in accordance with the procedures set forth in his/her then-current Evidence of Coverage. Once the Grievance is properly received by LIBERTY, LIBERTY shall resolve the Grievance in accordance with the time frames set forth in the Member's Evidence of Coverage.

5.2 Binding Arbitration. The Parties acknowledge and agree that, pursuant to the Evidence of Coverage, disputes between Members and LIBERTY shall be resolved through binding arbitration, provided that a Member must exhaust all LIBERTY grievance procedures prior to submitting a Grievance to arbitration.

ARTICLE VI
MISCELLANEOUS

6.1 Confidentiality.

(a) *Member Information.* The Parties shall maintain Member information and records in accordance with applicable laws and regulations, including but not necessarily limited to the Health Insurance Portability and Accountability Act and any rules and regulations promulgated thereunder (collectively, "HIPAA"), as well as the Health Information Technology for Economic and Clinical Health Act and any rules and regulations promulgated thereunder (collectively, "HITECH Act").

(b) *Other Information.* Group shall keep all of LIBERTY's confidential and/or proprietary information (collectively, "Confidential Information") in strictest confidence and use such Confidential Information for no other purpose than, and only to the extent necessary, to carry out administration of the Plan(s) and any other obligations under this Agreement. Moreover, Group shall not disclose any Confidential Information to a third party without the prior written authorization of LIBERTY. The obligations of confidentiality imposed by this Section 6.1(b) shall not apply to information that is, or becomes, publicly known and generally available to the public through no act or omission of Group or which is required to be disclosed by validly issued subpoena, by order of a court of competent jurisdiction or by applicable law or other legal or governmental process (collectively, "Required Disclosure"); provided, however, that in the case of Required Disclosure, Group shall promptly provide written notice to LIBERTY of such request(s). Upon termination or expiration of the Agreement, Group shall return to LIBERTY (or at LIBERTY's request, destroy) all Confidential Information.

6.2 Trademark Usage. Group shall use LIBERTY's trademarks, service marks and logos (collectively, "Marks") only in strict accordance with any policies or instructions provided by LIBERTY. Notwithstanding the foregoing, Group shall not: (a) use LIBERTY's Marks without prior approval from LIBERTY; (b) alter or modify LIBERTY's Marks or combine them with any other marks, words, designs or other material; or (c) use LIBERTY's Marks in any manner that misrepresents the relationship or that is otherwise likely to cause confusion or deceive consumers or the trade. Group shall comply with all applicable laws, rules and regulations in connection with its usage of LIBERTY's Marks and shall cooperate with LIBERTY's efforts to maintain and enforce its rights in and registrations for LIBERTY's Marks. To the extent Group develops and/or distributes materials that make reference to LIBERTY or otherwise include LIBERTY's Marks, Group shall obtain LIBERTY's prior written approval of such materials.

6.3 Applicable Law. This Agreement and the rights and obligations of the Parties shall be interpreted, construed and enforced in accordance with the laws of the State of California, without reference to conflict of laws principles. Any mediation or arbitration under this Agreement shall take place in Orange County, California; any litigation under this Agreement shall be filed and pursued in a court of proper venue in Orange County, California.

6.4 Waiver. No failure or delay by LIBERTY or any representative of LIBERTY in exercising any right, power, or privilege under this Agreement shall operate as a waiver thereof, nor will any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any other right, power, or privilege under this Agreement. In addition, the waiver by LIBERTY of a breach of any provision of this Agreement by Group shall not operate as or be construed as a waiver of any subsequent breach by Group.

6.5 Entire Agreement. This Agreement (including any attachments and exhibits) is the final expression of, and contains the entire agreement between, the Parties with respect to the subject matter hereof and supersedes all prior communications or understandings with respect thereto.

6.6 Severability. If any provision, term, covenant or condition contained in this Agreement is held by any court of competent jurisdiction to be invalid, unenforceable or void, such invalidity or unenforceability shall not affect the validity and enforceability of the remainder of the Agreement, and all other provisions, terms, covenants and conditions contained in the Agreement shall remain in full force and effect. In addition, any invalid, unenforceable, or void provision, term, covenant or condition of this Agreement shall be replaced with a valid and enforceable one that will achieve, to the extent possible, the economic, business, and other purposes of the invalid, unenforceable, or void provision, term, covenant or condition.

6.7 Amendments. Except as provided in Section 3.3 or except as necessary to comply with an applicable federal, state or local law, regulation, or guideline (in which case, LIBERTY may amend this Agreement without Group's consent in order to ensure compliance), this Agreement may not otherwise be amended, modified, changed, or supplemented in any way except by written instrument signed by an authorized signatory of each Party. Notwithstanding the foregoing, Group acknowledges and agrees that, due to periodic code set changes issued by agencies governing national dental procedure code sets, LIBERTY may make such changes to procedure codes without Group's consent.

6.8 Agreement Assignment. This Agreement may be freely assigned by LIBERTY without the consent of Group. This Agreement may not be assigned by Group without the prior written consent of LIBERTY. Notwithstanding the foregoing, this Agreement shall be binding upon, inure to the benefit of and be enforceable by the successors, assigns, heirs, executors and administrators of the Parties.

6.9 Survival. All of the Parties' continuing rights and obligations under this Agreement, including but not necessarily limited to the following provisions, survive termination of this Agreement: Sections 5.2, 6.1, and 6.2.

6.10 Headings. The headings of the sections/paragraphs of this Agreement are for convenience only and may not in any way affect the meaning or interpretation of this Agreement.

6.11 Counterparts. This Agreement may be executed in several counterparts (including by facsimile or by an electronic scan delivered by electronic mail) that together shall constitute a single agreement.

6.12 Notices. Any notices required to be given hereunder shall be in writing and shall be: (i) delivered in person to any signatory hereof, (ii) mailed by certified mail, postage prepaid, return receipt requested, or (iii) mailed by a commercial overnight courier that provides receipt of delivery. Notice shall be deemed effective upon the date of delivery. Either Party may at any time change its address by mailing a notice as required above. Until notice of a change of address is given, all such notices shall be given or addressed as follows:

To LIBERTY:
LIBERTY Dental Plan of California, Inc.
Attn: Executive Vice President
P.O. Box 26110
Santa Ana, CA 92799-6110

To Group:
PATHWAYS HOME HEALTH AND HOSPICE
Attn: NANCY RUMA
585 N MARY AVE
SUNNYVALE, CA 94085

IN WITNESS WHEREOF, this Agreement has been executed as of the Effective Date:

PATHWAYS HOME HEALTH AND HOSPICE **("GROUP"):**

_____
Authorized Signature

_____
Print Name

_____
Title

_____
Date

LIBERTY DENTAL PLAN OF CALIFORNIA, INC. ("LIBERTY"):

Authorized Signature

_____
Print Name

_____
Title

_____
Date

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

No Annual Deductible
No Annual Dollar Amount Maximum

- ✓ *Members must select, and be assigned to, a LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your assigned office will initiate a treatment plan or will initiate the specialty referral process with LIBERTY Dental Plan if the services are dentally necessary and outside the scope of general dentistry.*
- ✓ *Member Co-payments are payable to the dental office at the time services are rendered.*
- ✓ *This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.*
- ✓ *Dental procedures not listed as covered benefits are available at the dental office's usual and customary fee.*
- ✓ *For a complete description of your Plan, please refer to the Evidence of Coverage in addition to this Schedule.*

CDT Code	Description	Member Co-payment	Frequency
	Diagnostic Services		
D0120	Periodic oral evaluation	$0.00	
D0140	Limited oral evaluation	$0.00	
D0145	Oral evaluation under age 3	$0.00	
D0150	Comprehensive oral evaluation	$0.00	
D0160	Oral evaluation, problem focused	$0.00	
D0170	Re-evaluation, limited, problem focused	$0.00	
D0171	Re-evaluation, post operative office visit	$0.00	
D0180	Comprehensive periodontal evaluation	$0.00	
D0210	Intraoral, comprehensive series of radiographic images	$0.00	1 of (D0210, D0330, D0372, D0387, D0701, D0709) every 36 months
D0220	Intraoral, periapical, first radiographic image	$0.00	
D0230	Intraoral, periapical, each add 'l radiographic image	$0.00	
D0240	Intraoral, occlusal radiographic image	$0.00	
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	$0.00	
D0251	Extra-oral posterior dental radiographic image	$0.00	
D0270	Bitewing, single radiographic image	$0.00	
D0272	Bitewings, two radiographic images	$0.00	
D0273	Bitewings, three radiographic images	$0.00	
D0274	Bitewings, four radiographic images	$0.00	
D0277	Vertical bitewings, 7 to 8 radiographic images	$0.00	
D0330	Panoramic radiographic image	$0.00	1 of (D0210, D0330, D0372, D0387, D0701, D0709) every 36 months
D0372	Intraoral tomosynthesis, comprehensive series of radiographic images	$0.00	
D0373	Intraoral tomosynthesis, bitewing radiographic image	$0.00	
D0374	Intraoral tomosynthesis, periapical radiographic image	$0.00	
D0387	Intraoral tomosynthesis, comprehensive series, radiographic images, image capture only	$0.00	1 of (D0210, D0330, D0372, D0387, D0701, D0709) every 36 months
D0388	Intraoral tomosynthesis, bitewing radiographic image, image capture only	$0.00	
D0389	Intraoral tomosynthesis, periapical radiographic image, image capture only	$0.00	
D0396	3D printing of a 3D dental surface scan	$0.00	
D0414	Laboratory process of microbial specimen, culture, sensitivity, prep, report	$26.00	
D0415	Collection of microorganisms for culture	$26.00	
D0425	Caries susceptibility tests	$12.00	
D0460	Pulp vitality tests	$0.00	
D0461	Testing for cracked tooth	$0.00	
D0470	Diagnostic casts	$0.00	
D0472	Accession of tissue, gross exam, prep & report	$26.00	
D0473	Accession of tissue, gross/micro. exam, prep, report	$26.00	
D0474	Accession of tissue, gross/micro. exam, report	$26.00	
D0701	Panoramic radiographic image, image capture only	$0.00	1 of (D0210, D0330, D0372, D0387, D0701, D0709) every 36 months
D0705	Extra-oral posterior dental radiographic image, image capture only	$0.00	
D0706	Intraoral, occlusal radiographic image, image capture only	$0.00	
D0707	Intraoral, periapical radiographic image, image capture only	$0.00	
D0708	Intraoral, bitewing radiographic image, image capture only	$0.00	
D0709	Intraoral, comprehensive series of radiographic images, image capture only	$0.00	1 of (D0210, D0330, D0372, D0387, D0701, D0709) every 36 months
	Preventive Services		
D1110	Prophylaxis, adult	$0.00	1 of (D1110, D1120, D4346) every 6 months
	Prophylaxis, adult (additional prophylaxis)	$45.00	
D1120	Prophylaxis, child	$0.00	
	Prophylaxis, child (additional prophylaxis)	$35.00	
D1206	Topical application of fluoride varnish	$0.00	1 of (D1206, D1208) every 6 months, additional D1208 covered up to the 18th birthday (copay applies)
D1208	Topical application of fluoride, excluding varnish	$0.00	
	up to the 18th birthday (additional fluoride)	$10.00	
D1310	Nutritional counseling for control of dental disease	$0.00	
D1320	Tobacco counseling, control/prevention oral disease	$0.00	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	$0.00	
D1330	Oral hygiene instruction	$0.00	
D1351	Sealant, per tooth	$25.00	1 (D1351) per tooth every 36 months, limited to first and second molars, for dependent children up to the 14th birthday
D1353	Sealant repair, per tooth	$0.00	1 (D1353) per tooth every 36 months, limited to first and second molars, for dependent children up to the 14th birthday
D1510	Space maintainer, fixed, unilateral, per quadrant	$20.00	
D1516	Space maintainer, fixed, bilateral, maxillary	$20.00	

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
	Preventive Services (continued)		
D1517	Space maintainer, fixed, bilateral, mandibular	$20.00	
D1520	Space maintainer, removable, unilateral, per quadrant	$20.00	
D1526	Space maintainer, removable, bilateral, maxillary	$20.00	
D1527	Space maintainer, removable, bilateral, mandibular	$20.00	
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	$0.00	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	$0.00	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	$0.00	
D1556	Removal of fixed unilateral space maintainer, per quadrant	$5.00	
D1557	Removal of fixed bilateral space maintainer, maxillary	$5.00	
D1558	Removal of fixed bilateral space maintainer, mandibular	$5.00	
D1575	Distal shoe space maintainer, fixed, per quadrant	$20.00	
	Restorative Services		
D2140	Amalgam, one surface, primary or permanent	$5.00	Not payable within 12 months of initial filling if performed by the same provider or office
D2150	Amalgam, two surfaces, primary or permanent	$7.00	
D2160	Amalgam, three surfaces, primary or permanent	$9.00	
D2161	Amalgam, four or more surfaces, primary or permanent	$10.00	
D2330	Resin-based composite, one surface, anterior	$8.00	
D2331	Resin-based composite, two surfaces, anterior	$10.00	
D2332	Resin-based composite, three surfaces, anterior	$14.00	
D2335	Resin-based composite, four or more surfaces	$14.00	
D2390	Resin-based composite crown, anterior	$0.00	
D2391	Resin-based composite, one surface, posterior	$55.00	
D2392	Resin-based composite, two surfaces, posterior	$59.00	
D2393	Resin-based composite, three surfaces, posterior	$65.00	
D2394	Resin-based composite, four or more surfaces, posterior	$84.00	

***GUIDELINES for Inlays, Onlays, and Single Crowns:**

The total maximum amount chargeable to the member for elective upgraded procedures (explained below) is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure.

1. Brand name restorations: (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits.

2. Benefits for anterior and bicuspid teeth: Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure.

3. Benefits for molar teeth: Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure.

4. Base metal is the benefit: If elected, a)noble, b)high noble metal, or c) titanium may be considered an elective upgraded procedure.

D2510	Inlay, metallic, one surface	$132.00	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D2520	Inlay, metallic, two surfaces	$150.00	
D2530	Inlay, metallic, three or more surfaces	$158.00	
D2542	Onlay, metallic, two surfaces	$158.00	
D2543	Onlay, metallic, three surfaces	$166.00	
D2544	Onlay, metallic, four or more surfaces	$175.00	
D2610	Inlay, porcelain/ceramic, one surface	$140.00*	
D2620	Inlay, porcelain/ceramic, two surfaces	$150.00*	
D2630	Inlay, porcelain/ceramic, three or more surfaces	$158.00*	
D2642	Onlay, porcelain/ceramic, two surfaces	$166.00*	
D2643	Onlay, porcelain/ceramic, three surfaces	$175.00*	
D2644	Onlay, porcelain/ceramic, four or more surfaces	$183.00*	
D2650	Inlay, resin-based composite, one surface	$132.00*	
D2651	Inlay, resin-based composite, two surfaces	$140.00*	
D2652	Inlay, resin-based composite, three or more surfaces	$158.00*	
D2662	Onlay, resin-based composite, two surfaces	$158.00*	
D2663	Onlay, resin-based composite, three surfaces	$166.00*	
D2664	Onlay, resin-based composite, four or more surfaces	$175.00*	
D2710	Crown, resin-based composite (indirect)	$120.00*	
D2712	Crown, ¾ resin-based composite (indirect)	$123.00*	
D2720	Crown, resin with high noble metal	$175.00*	
D2721	Crown, resin with predominantly base metal	$175.00*	
D2722	Crown, resin with noble metal	$175.00*	
D2740	Crown, porcelain/ceramic	$175.00*	
D2750	Crown, porcelain fused to high noble metal	$185.00*	
D2751	Crown, porcelain fused to predominantly base metal	$185.00*	
D2752	Crown, porcelain fused to noble metal	$185.00*	
D2753	Crown, porcelain fused to titanium and titanium alloys	$185.00*	
D2780	Crown, ¾ cast high noble metal	$185.00*	
D2781	Crown, ¾ cast predominantly base metal	$185.00	
D2782	Crown, ¾ cast noble metal	$185.00*	
D2783	Crown, ¾ porcelain/ceramic	$185.00*	
D2790	Crown, full cast high noble metal	$175.00*	
D2791	Crown, full cast predominantly base metal	$175.00	
D2792	Crown, full cast noble metal	$175.00*	
D2794	Crown, titanium and titanium alloys	$175.00*	
D2799	Interim crown	$70.00	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$0.00	

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
	Restorative Services (continued)		
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	$5.00	
D2920	Re-cement or re-bond crown	$0.00	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	$40.00	
D2930	Prefabricated stainless steel crown, primary tooth	$40.00	
D2931	Prefabricated stainless steel crown, permanent tooth	$60.00	
D2932	Prefabricated resin crown	$15.00	
D2933	Prefabricated stainless steel crown with resin window	$45.00	
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	$45.00	
D2940	Placement of interim direct restoration	$0.00	
D2950	Core buildup, including any pins when required	$45.00	
D2951	Pin retention, per tooth, in addition to restoration	$8.00	
D2952	Post and core in addition to crown, indirectly fabricated	$45.00	
D2953	Each additional indirectly fabricated post, same tooth	$20.00	
D2954	Prefabricated post and core in addition to crown	$45.00	
D2955	Post removal	$18.00	
D2956	Removal of an indirect restoration on a natural tooth	$0.00	Inclusive with D2510-D2799, D2910, D2915, D2920, D2921-D2934, D2960-D2962. 1 per tooth every 5 year period, covered for members age 16 and over
D2957	Each additional prefabricated post, same tooth	$20.00	
D2960	Labial veneer (resin laminate), direct	$200.00	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D2961	Labial veneer (resin laminate), indirect	$325.00	
D2962	Labial veneer (porcelain laminate), indirect	$500.00	
D2971	Additional procedure to customize new crown, existing partial denture frame	$28.00	
D2976	Band stabilization, per tooth	$0.00	Inclusive with D2160, D2161, D2393, D2394
D2980	Crown repair necessitated by restorative material failure	$28.00	
	Endodontic Services		
D3110	Pulp cap, direct (excluding final restoration)	$0.00	
D3120	Pulp cap, indirect (excluding final restoration)	$0.00	
D3220	Therapeutic pulpotomy (excluding final restoration)	$12.00	
D3221	Pulpal debridement, primary and permanent teeth	$10.00	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$0.00	
D3240	Pulpal therapy, posterior, primary tooth (excluding final restoration)	$0.00	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$40.00	
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$48.00	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$62.00	
D3331	Treatment of root canal obstruction; non-surgical access	$192.00	
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	$70.00	
D3333	Internal root repair of perforation defects	$96.00	
D3346	Retreatment of previous root canal therapy, anterior	$40.00	
D3347	Retreatment of previous root canal therapy, premolar	$48.00	
D3348	Retreatment of previous root canal therapy, molar	$62.00	
D3351	Apexification/recalcification, initial visit	$70.00	
D3352	Apexification/recalcification, interim medication replacement	$70.00	
D3353	Apexification/recalcification, final visit	$70.00	
D3410	Apicoectomy, anterior	$45.00	
D3421	Apicoectomy, premolar (first root)	$45.00	
D3425	Apicoectomy, molar (first root)	$45.00	
D3426	Apicoectomy, (each additional root)	$20.00	
D3430	Retrograde filling, per root	$15.00	
D3450	Root amputation, per root	$15.00	
D3910	Surgical procedure for isolation of tooth with rubber dam	$17.00	
D3920	Hemisection, not including root canal therapy	$35.00	
D3950	Canal preparation and fitting of preformed dowel or post	$0.00	
	Periodontal Services		
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$35.00	1 of (D4210-D4285) per site/quad every 36 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$10.00	
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	$0.00	
D4240	Gingival flap procedure, four or more teeth per quadrant	$0.00	
D4241	Gingival flap procedure, one to three teeth per quadrant	$0.00	
D4245	Apically positioned flap	$96.00	
D4249	Clinical crown lengthening, hard tissue	$195.00	
D4260	Osseous surgery, four or more teeth per quadrant	$65.00	
D4261	Osseous surgery, one to three teeth per quadrant	$65.00	
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	$135.00	
D4264	Bone replacement graft, retained natural tooth, each additional site	$70.00	
D4270	Pedicle soft tissue graft procedure	$236.00	
D4273	Autogenous connective tissue graft procedure, first tooth	$236.00	
D4274	Mesial/distal wedge procedure, single tooth	$140.00	
D4275	Non-autogenous connective tissue graft, first tooth	$236.00	
D4277	Free soft tissue graft, first tooth	$236.00	
D4278	Free soft tissue graft, each additional tooth	$236.00	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	$236.00	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	$236.00	

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
	Periodontal Services (continued)		
D4322	Splint, intra-coronal; natural teeth or prosthetic crowns	$80.00	
D4323	Splint, extra-coronal; natural teeth or prosthetic crowns	$80.00	
GUIDELINE: No more than two (2) quadrants of periodontal scaling and root planing per appointment/ per day are allowable.			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$12.00	1 of (D4341, D4342) per site quad, every 24 month
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$12.00	
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$0.00	1 of (D1110, D1120, D4346) every 6 months
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	$8.00	1 (D4355) every 24 months
D4381	Localized delivery of antimicrobial agent/per tooth	$25.00	
D4910	Periodontal maintenance	$10.00	
D4920	Unscheduled dressing change (other than treating dentist or staff)	$10.00	
	Removable Prosthodontic Services		
D5110	Complete denture, maxillary	$250.00	1 of (D5110-D5283, D5877, D5878) per arch every 5 year period, if the appliance cannot be made functional through reline or repair
D5120	Complete denture, mandibular	$250.00	
D5130	Immediate denture, maxillary	$250.00	
D5140	Immediate denture, mandibular	$250.00	
D5211	Maxillary partial denture, resin base	$205.00	
D5212	Mandibular partial denture, resin base	$205.00	
D5213	Maxillary partial denture, cast metal, resin base	$235.00	
D5214	Mandibular partial denture, cast metal, resin base	$235.00	
D5221	Immediate maxillary partial denture, resin base	$205.00	
D5222	Immediate mandibular partial denture, resin base	$205.00	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	$235.00	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	$235.00	
D5225	Maxillary partial denture, flexible base	$300.00	
D5226	Mandibular partial denture, flexible base	$300.00	
D5227	Immediate maxillary partial denture, flexible base	$300.00	
D5228	Immediate mandibular partial denture, flexible base	$300.00	
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	$132.00	
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	$132.00	
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	$132.00	1 of (D5284, D5286) per site every 5 year period, if the appliance cannot be made function through reline or repair
D5286	Removable unilateral partial denture, one piece resin, per quadrant	$132.00	
D5410	Adjust complete denture, maxillary	$0.00	
D5411	Adjust complete denture, mandibular	$0.00	
D5421	Adjust partial denture, maxillary	$0.00	
D5422	Adjust partial denture, mandibular	$0.00	
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, per tooth	$18.00	
D5611	Repair resin partial denture base, mandibular	$25.00	
D5612	Repair resin partial denture base, maxillary	$25.00	
D5621	Repair cast partial framework, mandibular	$30.00	
D5622	Repair cast partial framework, maxillary	$30.00	
D5630	Repair or replace broken retentive clasping materials, per tooth	$35.00	
D5640	Replace missing or broken teeth, partial denture, per tooth	$35.00	
D5650	Add tooth to existing partial denture, per tooth	$30.00	
D5660	Add clasp to existing partial denture, per tooth	$30.00	
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	$45.00	
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	$45.00	
D5710	Rebase complete maxillary denture	$0.00	
D5711	Rebase complete mandibular denture	$0.00	
D5720	Rebase maxillary partial denture	$0.00	
D5721	Rebase mandibular partial denture	$0.00	
D5725	Rebase hybrid prosthesis	$0.00	
D5730	Reline complete maxillary denture, direct	$60.00	2 of (D5730-D5761) per arch every 12 months
D5731	Reline complete mandibular denture, direct	$60.00	
D5740	Reline maxillary partial denture, direct	$60.00	
D5741	Reline mandibular partial denture, direct	$60.00	
D5750	Reline complete maxillary denture, indirect	$75.00	
D5751	Reline complete mandibular denture, indirect	$75.00	
D5760	Reline maxillary partial denture, indirect	$75.00	
D5761	Reline mandibular partial denture, indirect	$75.00	
D5765	Soft liner for complete or partial removable denture, indirect	$60.00	
D5810	Interim complete denture, maxillary	$100.00	1 of (D5810-D5821) per arch every 5 year period
D5811	Interim complete denture, mandibular	$100.00	
D5820	Interim partial denture, maxillary	$0.00	
D5821	Interim partial denture, mandibular	$0.00	
D5851	Tissue conditioning, mandibular	$25.00	
D5850	Tissue conditioning, maxillary	$25.00	
D5877	Duplication of complete denture, maxillary	$125.00	1 of (D5110-D5283, D5877, D5878) per arch every 5 year period, if the appliance cannot be made functional through reline or repair
D5878	Duplication of complete denture, mandibular	$125.00	

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
GUIDELINE: Implants and all services associated with implants are listed at the actual member co-payment amount. No additional fee is allowable for porcelain, noble metal, high noble metal, or titanium for implants and procedures associated with implants.			
	Implant Services		
D6010	Surgical placement of implant body, endosteal	$2,000.00	
D6049	Scaling and debridement in the presence of peri-implantitis inflammation of a single implant	$0.00	1 of (D6049, D6081, D6180) per implant every 12 months
D6056	Prefabricated abutment, includes modification and placement	$210.00	
D6058	Abutment supported porcelain/ceramic crown	$1,110.00	
D6059	Abutment supported porcelain fused to high noble crown	$1,096.00	
D6060	Abutment supported porcelain fused to base metal crown	$1,035.00	
D6061	Abutment supported porcelain fused to noble metal crown	$1,056.00	
D6062	Abutment supported cast metal crown, high noble	$1,003.00	
D6063	Abutment supported cast metal crown, base metal	$861.00	
D6064	Abutment supported cast metal crown, noble metal	$912.00	
D6065	Implant supported porcelain/ceramic crown	$1,040.00	
D6066	Implant supported crown, porcelain fused to high noble alloys	$1,013.00	
D6067	Implant supported crown, high noble alloys	$984.00	
D6068	Abutment supported retainer, porcelain/ceramic FPD	$1,110.00	
D6069	Abutment supported retainer, metal FPD, high noble	$1,096.00	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$1,035.00	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	$1,056.00	
D6072	Abutment supported retainer, cast metal FPD, high noble	$1,028.00	
D6073	Abutment supported retainer, cast metal FPD, base metal	$930.00	
D6074	Abutment supported retainer, cast metal FPD, noble	$1,005.00	
D6075	Implant supported retainer for ceramic FPD	$1,092.00	
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	$1,064.00	
D6077	Implant supported retainer for metal FPD, high noble alloys	$984.00	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	$0.00	1 of (D6049, D6081, D6180) per implant every 12 months
D6082	Implant supported crown, porcelain fused to predominantly base alloys	$984.00	
D6083	Implant supported crown, porcelain fused to noble alloys	$984.00	
D6084	Implant supported crown, porcelain fused to titanium and titanium alloys	$984.00	
D6085	Interim implant crown	$70.00	
D6086	Implant supported crown, predominantly base alloys	$984.00	
D6087	Implant supported crown, noble alloys	$984.00	
D6088	Implant supported crown, titanium and titanium alloys	$984.00	
D6089	Accessing and retorquing loose implant screw, per screw	$0.00	Inclusive with D6096
D6092	Re-cement or re-bond implant/abutment supported crown	$45.00	
D6093	Re-cement or re-bond implant/abutment supported FPD	$65.00	
D6094	Abutment supported crown, titanium, and titanium alloys	$670.00	
D6096	Remove broken implant retaining screw	$75.00	
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	$984.00	
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	$984.00	
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	$984.00	
D6105	Removal of implant body not requiring bone removal or flap elevation	$8.00	
D6120	Implant supported retainer, porcelain fused to titanium and titanium alloys	$984.00	
D6121	Implant supported retainer for metal FPD, predominantly base alloys	$984.00	
D6122	Implant supported retainer for metal FPD, noble alloys	$984.00	
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	$984.00	
D6180	Implant maintenance procedures, full arch fixed hybrid prosthesis is not removed, including cleansing	$0.00	1 of (D6049, D6081, D6180) per implant every 12 months
D6194	Abutment supported retainer crown for FPD titanium, titanium and titanium alloys	$670.00	
D6195	Abutment supported retainer, porcelain fused to titanium and titanium alloys	$984.00	
D6196	Removal of an indirect restoration on an implant retained abutment	$0.00	
D6197	Replacement of restorative material, close access opening of screw-retained implant supported prosthesis, per implant	$55.00	1 (D6197) every 6 months, per implant
	Fixed Prosthodontic Services		
***GUIDELINES for Pontics, Retainer Crowns, Retainer Inlays, Retainer Onlays:** **The total maximum amount chargeable to the member for elective upgraded procedures** (explained below) is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure. **1. Brand name restorations:** (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits. **2. Benefits for anterior and bicuspid teeth:** Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure. **3. Benefits for molar teeth:** Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure. **4. Base metal is the benefit:** If elected, a)noble, b)high noble metal, or c) titanium may be considered an elective upgraded procedure.			
D6205	Pontic, indirect resin based composite	$145.00*	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D6210	Pontic, cast high noble metal	$145.00*	
D6211	Pontic, cast predominantly base metal	$145.00	
D6212	Pontic, cast noble metal	$145.00*	
D6214	Pontic, titanium, and titanium alloys	$145.00*	
D6240	Pontic, porcelain fused to high noble metal	$145.00*	

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
	Fixed Prosthodontic Services (continued)		
D6241	Pontic, porcelain fused to predominantly base metal	$145.00*	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D6242	Pontic, porcelain fused to noble metal	$145.00*	
D6243	Pontic, porcelain fused to titanium and titanium alloys	$145.00*	
D6245	Pontic, porcelain/ceramic	$100.00*	
D6250	Pontic, resin with high noble metal	$185.00*	
D6251	Pontic, resin with predominantly base metal	$185.00*	
D6252	Pontic, resin with noble metal	$185.00*	
D6253	Interim pontic	$122.00	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	$90.00*	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	$90.00*	
D6549	Resin retainer, for resin bonded fixed prosthesis	$90.00	
D6600	Retainer inlay, porcelain/ceramic, two surfaces	$150.00*	
D6601	Retainer inlay, porcelain/ceramic, three or more surfaces	$160.00*	
D6602	Retainer inlay, cast high noble metal, two surfaces	$150.00*	
D6603	Retainer inlay, cast high noble metal, three or more surfaces	$160.00*	
D6604	Retainer inlay, cast base metal, two surfaces	$150.00	
D6605	Retainer inlay, cast base metal, three or more surfaces	$160.00	
D6606	Retainer inlay, cast noble metal, two surfaces	$140.00*	
D6607	Retainer inlay, cast noble metal, three or more surfaces	$160.00*	
D6608	Retainer onlay, porcelain/ceramic, two surfaces	$166.00*	
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	$175.00*	
D6610	Retainer onlay, cast high noble metal, two surfaces	$160.00*	
D6611	Retainer onlay, cast high noble metal, three or more surfaces	$166.00*	
D6612	Retainer onlay, cast base metal, two surfaces	$160.00	
D6613	Retainer onlay, cast base metal, three or more surfaces	$166.00	
D6614	Retainer onlay, cast noble metal, two surfaces	$160.00*	
D6615	Retainer onlay, cast noble metal three or more surfaces	$166.00*	
D6624	Retainer inlay, titanium	$160.00*	
D6634	Retainer onlay, titanium	$166.00*	
D6710	Retainer crown, indirect resin based composite	$88.00*	
D6720	Retainer crown, resin with high noble metal	$100.00*	
D6721	Retainer crown, resin with predominantly base metal	$100.00*	
D6722	Retainer crown, resin with noble metal	$100.00*	
D6740	Retainer crown, porcelain/ceramic	$145.00*	
D6750	Retainer crown, porcelain fused to high noble metal	$185.00*	
D6751	Retainer crown, porcelain fused to predominantly base metal	$185.00*	
D6752	Retainer crown, porcelain fused to noble metal	$185.00*	
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	$185.00*	
D6780	Retainer crown, ¾ cast high noble metal	$185.00*	
D6781	Retainer crown, ¾ cast predominantly base metal	$185.00	
D6782	Retainer crown, ¾ cast noble metal	$185.00*	
D6783	Retainer crown, ¾ porcelain/ceramic	$175.00*	
D6784	Retainer crown ¾, titanium and titanium alloys	$185.00*	
D6790	Retainer crown, full cast high noble metal	$145.00*	
D6791	Retainer crown, full cast predominantly base metal	$145.00	
D6792	Retainer crown, full cast noble metal	$145.00*	
D6793	Interim retainer crown	$70.00	
D6794	Retainer crown, titanium and titanium alloys	$145.00*	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D6930	Re-cement or re-bond fixed partial denture	$0.00	
D6940	Stress breaker	$25.00	
D6980	Fixed partial denture repair, restorative material failure	$30.00	
	Oral & Maxillofacial Services		
D7111	Extraction, coronal remnants, primary tooth	$5.00	
D7140	Extraction, erupted tooth or exposed root	$8.00	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$15.00	
D7220	Removal of impacted tooth, soft tissue	$20.00	
D7230	Removal of impacted tooth, partially bony	$24.00	
D7240	Removal of impacted tooth, completely bony	$28.00	
D7241	Removal impacted tooth, complete bony, complication	$28.00	
D7250	Removal of residual tooth roots (cutting procedure)	$0.00	
D7259	Nerve dissection	$0.00	1 (D7259) per tooth in a lifetime; limited to teeth #17 and #32. Inclusive with D7241. Must be performed by licensed Oral Surgeon.
D7261	Primary closure of a sinus perforation	$170.00	
D7270	Tooth reimplantation and/or stabilization, accident	$160.00	
D7280	Exposure of an unerupted tooth	$80.00	
D7282	Mobilization of erupted/malpositioned tooth	$55.00	
D7283	Placement, device to facilitate eruption, impaction	$55.00	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	$0.00	
D7286	Incisional biopsy of oral tissue, soft	$0.00	
D7287	Exfoliative cytological sample collection	$10.00	
D7288	Brush biopsy, transepithelial sample collection	$10.00	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$50.00	

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
	Oral & Maxillofacial Services (continued)		
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$50.00	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$50.00	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$50.00	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	$70.00	
D7350	Vestibuloplasty, ridge extension	$100.00	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	$80.00	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	$160.00	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	$90.00	
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	$125.00	
D7471	Removal of lateral exostosis, maxilla or mandible	$96.00	
D7472	Removal of torus palatinus	$70.00	
D7473	Removal of torus mandibularis	$70.00	
D7485	Reduction of osseous tuberosity	$50.00	
D7509	Marsupialization of odontogenic cyst	$0.00	
D7510	Incision & drainage of abscess, intraoral soft tissue	$15.00	
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	$20.00	
D7520	Incision & drainage of abscess, extraoral soft tissue	$15.00	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	$20.00	
D7530	Remove foreign body, mucosa, skin, tissue	$18.00	
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$45.00	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	$0.00	
D7961	Buccal/labial frenectomy (frenulectomy)	$25.00	
D7962	Lingual frenectomy (frenulectomy)	$25.00	
D7963	Frenuloplasty	$25.00	
D7970	Excision of hyperplastic tissue, per arch	$40.00	
D7971	Excision of pericoronal gingiva	$35.00	
D7993	Surgical placement of craniofacial implant, extra oral	$2,000.00	
D7994	Surgical placement: zygomatic implant	$2,000.00	
	Adjunctive General Services		
D9110	Palliative treatment of dental pain, per visit	$18.00	
D9120	Fixed partial denture sectioning	$5.00	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	$0.00	
D9211	Regional block anesthesia	$0.00	
D9212	Trigeminal division block anesthesia	$0.00	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0.00	
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0.00	
**GUIDELINE: Deep sedation/general anesthesia is a covered benefit only when in conjunction with covered oral surgery and pedodontic procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure; and when warranted by documented conditions that local anesthetic and contraindicated. General anesthesia, as used for dental pain control, means the elimination of all sensations accompanied by a state of unconsciousness. Patient apprehension and/or nervousness are not of themselves sufficient justification for deep sedation/general anesthesia or intravenous conscious sedation/analgesia.			
D9222	Administration of deep sedation/general anesthesia, first 15 minute increment, or any portion thereof	$125.00**	
D9223	Administration of deep sedation/general anesthesia, each subsequent 15 minute increment, or any portion thereof	$125.00**	
D9224	Administration of general anesthesia with advanced airway, first 15 minute increment, or any portion thereof	$125.00**	
D9225	Administration of general anesthesia with advanced airway, each subsequent 15 minute increment, or any portion thereof	$125.00**	
D9230	Administration of nitrous oxide	$35.00	
D9239	Administration of moderate sedation, intravenous, first 15 minute increment, or any portion thereof	$125.00**	
D9243	Administration of moderate sedation, intravenous, each subsequent 15 minute increment, or any portion thereof	$125.00**	
D9244	In-office administration of minimal sedation, single drug, enteral	$100.00	
D9245	Administration of moderate sedation, enteral	$100.00	
D9246	Administration of moderate sedation, non-intravenous parenteral, first 15 minute increment, or any portion thereof	$100.00	
D9247	Administration of moderate sedation, non-intravenous parenteral, each subsequent 15 minute increment, or any portion thereof	$0.00	
D9310	Consultation, other than requesting dentist	$0.00	
D9311	Consultation with a medical health care professional	$0.00	
D9430	Office visit, observation, regular hours, no other services	$0.00	
D9440	Office visit, after regularly scheduled hours	$24.00	
D9450	Case presentation, subsequent, detailed, extensive treatment planning	$0.00	
D9630	Drugs or medicaments dispensed in the office for home use	$14.00	
D9910	Application of desensitizing medicament	$5.00	
D9911	Application of desensitizing resin for cervical, root surface, per tooth	$5.00	
D9912	Pre-visit patient screening	$0.00	
D9930	Treatment of complications, post surgical, unusual, by report	$10.00	
D9942	Repair and/or reline of occlusal guard	$45.00	
D9944	Occlusal guard, hard appliance, full arch	$175.00	
D9945	Occlusal guard, soft appliance, full arch	$175.00	

CDT Code	Description	Member Co-payment	Frequency
	Adjunctive General Services (continued)		
D9946	Occlusal guard, hard appliance, partial arch	$175.00	
D9950	Occlusion analysis, mounted case	$0.00	
D9951	Occlusal adjustment, limited	$15.00	
D9952	Occlusal adjustment, complete	$18.00	
D9971	Odontoplasty, per tooth	$5.00	
D9986	Missed appointment	$20.00	
D9987	Cancelled appointment	$0.00	
D9991	Dental case management, addressing appointment compliance barriers	$0.00	
D9992	Dental case management, care coordination	$0.00	
D9993	Dental case management, motivational interviewing	$0.00	
D9994	Dental case management, patient education to improve oral health literacy	$0.00	
D9997	Dental case management, patients with special health care needs	$0.00	
	Office visit, per visit	$0.00	

LIBERTY Dental Plan of California, Inc.

Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

Limitations:

1. Fabricated crowns, onlays and inlays may be covered when a tooth with a good prognosis requires restoration but has insufficient remaining structure to reliably retain a filling. Coverage for these procedures limited to members age 16 and over.
2. Procedures that appear to have a poor prognosis as determined by a licensed LIBERTY dentist consultant are not covered.
3. Localized delivery of antimicrobial agents may be covered 4-6 weeks after the completion of scaling and root planing as an adjunctive procedure for 2 non-responsive sites in a quadrant with 5mm pockets or deeper plus inflammation.
4. For treatment plans involving 7 or more units of crowns and/or fixed partial dentures (bridges), contracted providers may charge an additional $200 co-payment per unit. In such cases, the first 6 units are covered at the specified member co-payment amount only, as documented in this Schedule of Benefits.
5. Fixed partial dentures (bridges) are covered when: replacing a “like-for-like” existing fixed partial denture with identical pontics and abutment teeth with good prognosis; abutment teeth qualify for crowns on their own merit; there is only one missing permanent tooth in a full arch and the bridge would have opposing teeth in the opposite arch.
6. Pediatric referrals, if authorized by LIBERTY, are covered only for dependent children through the age of 6 unless the child qualifies under the American with Disabilities Act (ADA).

Exclusions:

1. Any procedure not specifically listed as a Covered Benefit.
2. Replacement of lost or stolen prosthetics or appliances including partial dentures, full dentures, and orthodontic appliances.
3. General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist other than those situations described in the Schedule of Benefits (**).
4. Treatment started prior to coverage or after termination of coverage.
5. Procedures, appliances, or restorations to treat temporomandibular joint dysfunctions (e.g. adjustments/corrections to the facial bones), congenital or developmental situations (including supernumerary teeth) or medically induced dental disorders, including but not limited to: myofunctional treatment (e.g. speech therapy), or myoskeletal dysfunctions, unless otherwise covered as an orthodontic benefit.
6. Services for cosmetic purposes or for conditions that are a result of hereditary developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
7. Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice.
8. Procedures performed on natural teeth solely to increase vertical dimension or restore occlusion.
9. Any service performed outside of your assigned dental office, unless expressly authorized by LIBERTY Dental Plan, or unless as outlined and covered in the “Emergency Dental Care” section of the Evidence of Coverage.
10. The removal of asymptomatic, unerupted third molars (or other teeth) that appear to have an unimpeded pathway to eruption and no active pathology.
11. Procedures or appliances that are provided by a dentist who specializes in prosthodontic services.
12. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding occlusion or maintaining chewing surfaces or teeth that are out of alignment or for stabilizing teeth. Examples of such treatment are equilibration and periodontal splinting.
13. Any routine dental services performed by a dentist or dental specialist in an inpatient/outpatient hospital setting.
14. Consultations for non-covered services.

LIBERTY Dental Plan of California, Inc.

Ortho-275 PLAN SCHEDULE OF BENEFITS

Primary Dentition: Teeth developed and erupted first in order of time.

Transitional Dentition: The Final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

Treatment must be provided by a LIBERTY Dental Plan contracted orthodontic provider.
Any procedure not listed is available at the provider's usual and customary fee

CDT Code	Description	Member Co-payment
D0340	2D cephalometric radiographic image, measurement and analysis	$150.00
D0396	3D printing of a 3D dental surface scan	$125.00
D0470	Diagnostic casts	$125.00
D0702	2-D cephalometric radiographic image, image capture only	$150.00
D9310	Consultation, other than requesting dentist	$0.00
D8010	Limited orthodontic treatment of the primary dentition	$1,550.00
D8020	Limited orthodontic treatment of the transitional dentition	$1,550.00
D8030	Limited orthodontic treatment of the adolescent dentition	$1,550.00
D8040	Limited orthodontic treatment of the adult dentition	$1,550.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,775.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,775.00
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,950.00
D8091	Comprehensive orthodontic treatment with orthognathic surgery	$1,775.00
D8210	Removable appliance therapy	$350.00
D8220	Fixed appliance therapy	$350.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$0.00
D8670	Periodic orthodontic treatment visit	$0.00
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	$0.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$325.00
D9986	Missed appointment	$25.00
D9987	Cancelled appointment	$0.00

Orthodontic Exclusions:

1. Replacement of lost or stolen orthodontic appliances
2. Lost, stolen or broken appliances
3. Orthodontic treatment started prior to member's effective date of coverage unless covered through an orthodontic takeover provision.
4. Extractions for orthodontic purposes, (will not be applied if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition).
5. Treatment in progress at the time of eligibility, unless included as an orthodontic rider to the groups benefits.
6. Temporomandibular joint syndrome (TMJ) surgical orthodontics
7. Myofunctional therapy
8. Treatment of cleft palate
9. Treatment of micrognathia
10. Treatment of macroglossia
11. Changes in orthodontic treatment necessitated by accident of any kind.
12. Orthodontic coverage is limited to 24 months of treatment, followed by 24 months of retention office visits.
13. Services provided after the 24th month of treatment and/or retention is the responsibility of the patient at a fee not to exceed $130 per month.
14. In the event of termination the patient is responsible for the usual fee of the treating dentist pro-rated over the remainder of treatment and/or retention.

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

No Annual Deductible
No Annual Dollar Amount Maximum

- ✓ *Members must select, and be assigned to, a LIBERTY Dental Plan contracted dental office to utilize covered benefits. Your assigned office will initiate a treatment plan or will initiate the specialty referral process with LIBERTY Dental Plan if the services are dentally necessary and outside the scope of general dentistry.*
- ✓ *Member Co-payments are payable to the dental office at the time services are rendered.*
- ✓ *This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.*
- ✓ *Dental procedures not listed as covered benefits are available at the dental office's usual and customary fee.*
- ✓ *For a complete description of your Plan, please refer to the Evidence of Coverage in addition to this Schedule.*

CDT Code	Description	Member Co-payment	Frequency
	Diagnostic Services		
D0120	Periodic oral evaluation	$0.00	
D0140	Limited oral evaluation	$0.00	
D0145	Oral evaluation under age 3	$0.00	
D0150	Comprehensive oral evaluation	$0.00	
D0160	Oral evaluation, problem focused	$0.00	
D0170	Re-evaluation, limited, problem focused	$0.00	
D0171	Re-evaluation, post operative office visit	$0.00	
D0180	Comprehensive periodontal evaluation	$0.00	
D0210	Intraoral, comprehensive series of radiographic images	$0.00	1 of (D0210, D0330, D0372, D0387, D0701, D0709) every 36 months
D0220	Intraoral, periapical, first radiographic image	$0.00	
D0230	Intraoral, periapical, each add 'l radiographic image	$0.00	
D0240	Intraoral, occlusal radiographic image	$0.00	
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	$0.00	
D0251	Extra-oral posterior dental radiographic image	$0.00	
D0270	Bitewing, single radiographic image	$0.00	
D0272	Bitewings, two radiographic images	$0.00	
D0273	Bitewings, three radiographic images	$0.00	
D0274	Bitewings, four radiographic images	$0.00	
D0277	Vertical bitewings, 7 to 8 radiographic images	$0.00	
D0330	Panoramic radiographic image	$0.00	1 of (D0210, D0330, D0372, D0387, D0701, D0709) every 36 months
D0372	Intraoral tomosynthesis, comprehensive series of radiographic images	$0.00	
D0373	Intraoral tomosynthesis, bitewing radiographic image	$0.00	
D0374	Intraoral tomosynthesis, periapical radiographic image	$0.00	
D0387	Intraoral tomosynthesis, comprehensive series, radiographic images, image capture only	$0.00	1 of (D0210, D0330, D0372, D0387, D0701, D0709) every 36 months
D0388	Intraoral tomosynthesis, bitewing radiographic image, image capture only	$0.00	
D0389	Intraoral tomosynthesis, periapical radiographic image, image capture only	$0.00	
D0396	3D printing of a 3D dental surface scan	$0.00	
D0414	Laboratory process of microbial specimen, culture, sensitivity, prep, report	$26.00	
D0415	Collection of microorganisms for culture	$26.00	
D0425	Caries susceptibility tests	$12.00	
D0460	Pulp vitality tests	$0.00	
D0461	Testing for cracked tooth	$0.00	
D0470	Diagnostic casts	$0.00	
D0472	Accession of tissue, gross exam, prep & report	$26.00	
D0473	Accession of tissue, gross/micro. exam, prep, report	$26.00	
D0474	Accession of tissue, gross/micro. exam, report	$26.00	
D0701	Panoramic radiographic image, image capture only	$0.00	1 of (D0210, D0330, D0372, D0387, D0701, D0709) every 36 months
D0705	Extra-oral posterior dental radiographic image, image capture only	$0.00	
D0706	Intraoral, occlusal radiographic image, image capture only	$0.00	
D0707	Intraoral, periapical radiographic image, image capture only	$0.00	
D0708	Intraoral, bitewing radiographic image, image capture only	$0.00	
D0709	Intraoral, comprehensive series of radiographic images, image capture only	$0.00	1 of (D0210, D0330, D0372, D0387, D0701, D0709) every 36 months
	Preventive Services		
D1110	Prophylaxis, adult	$0.00	1 of (D1110, D1120, D4346) every 6 months
	Prophylaxis, adult (additional prophylaxis)	$45.00	
D1120	Prophylaxis, child	$0.00	
	Prophylaxis, child (additional prophylaxis)	$35.00	
D1206	Topical application of fluoride varnish	$0.00	1 of (D1206, D1208) every 6 months, additional D1208 covered up to the 18th birthday (copay applies)
D1208	Topical application of fluoride, excluding varnish	$0.00	
	up to the 18th birthday (additional fluoride)	$10.00	
D1310	Nutritional counseling for control of dental disease	$0.00	
D1320	Tobacco counseling, control/prevention oral disease	$0.00	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	$0.00	
D1330	Oral hygiene instruction	$0.00	
D1351	Sealant, per tooth	$25.00	1 (D1351) per tooth every 36 months, limited to first and second molars, for dependent children up to the 14th birthday
D1353	Sealant repair, per tooth	$0.00	1 (D1353) per tooth every 36 months, limited to first and second molars, for dependent children up to the 14th birthday
D1510	Space maintainer, fixed, unilateral, per quadrant	$20.00	
D1516	Space maintainer, fixed, bilateral, maxillary	$20.00	

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
	Preventive Services (continued)		
D1517	Space maintainer, fixed, bilateral, mandibular	$20.00	
D1520	Space maintainer, removable, unilateral, per quadrant	$20.00	
D1526	Space maintainer, removable, bilateral, maxillary	$20.00	
D1527	Space maintainer, removable, bilateral, mandibular	$20.00	
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	$0.00	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	$0.00	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	$0.00	
D1556	Removal of fixed unilateral space maintainer, per quadrant	$5.00	
D1557	Removal of fixed bilateral space maintainer, maxillary	$5.00	
D1558	Removal of fixed bilateral space maintainer, mandibular	$5.00	
D1575	Distal shoe space maintainer, fixed, per quadrant	$20.00	
	Restorative Services		
D2140	Amalgam, one surface, primary or permanent	$5.00	Not payable within 12 months of initial filling if performed by the same provider or office
D2150	Amalgam, two surfaces, primary or permanent	$7.00	
D2160	Amalgam, three surfaces, primary or permanent	$9.00	
D2161	Amalgam, four or more surfaces, primary or permanent	$10.00	
D2330	Resin-based composite, one surface, anterior	$8.00	
D2331	Resin-based composite, two surfaces, anterior	$10.00	
D2332	Resin-based composite, three surfaces, anterior	$14.00	
D2335	Resin-based composite, four or more surfaces	$14.00	
D2390	Resin-based composite crown, anterior	$0.00	
D2391	Resin-based composite, one surface, posterior	$55.00	
D2392	Resin-based composite, two surfaces, posterior	$59.00	
D2393	Resin-based composite, three surfaces, posterior	$65.00	
D2394	Resin-based composite, four or more surfaces, posterior	$84.00	

***GUIDELINES for Inlays, Onlays, and Single Crowns:**

The total maximum amount chargeable to the member for elective upgraded procedures (explained below) is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure.

1. Brand name restorations: (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits.

2. Benefits for anterior and bicuspid teeth: Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure.

3. Benefits for molar teeth: Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure.

4. Base metal is the benefit: If elected, a)noble, b)high noble metal, or c) titanium may be considered an elective upgraded procedure.

D2510	Inlay, metallic, one surface	$132.00	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D2520	Inlay, metallic, two surfaces	$150.00	
D2530	Inlay, metallic, three or more surfaces	$158.00	
D2542	Onlay, metallic, two surfaces	$158.00	
D2543	Onlay, metallic, three surfaces	$166.00	
D2544	Onlay, metallic, four or more surfaces	$175.00	
D2610	Inlay, porcelain/ceramic, one surface	$140.00*	
D2620	Inlay, porcelain/ceramic, two surfaces	$150.00*	
D2630	Inlay, porcelain/ceramic, three or more surfaces	$158.00*	
D2642	Onlay, porcelain/ceramic, two surfaces	$166.00*	
D2643	Onlay, porcelain/ceramic, three surfaces	$175.00*	
D2644	Onlay, porcelain/ceramic, four or more surfaces	$183.00*	
D2650	Inlay, resin-based composite, one surface	$132.00*	
D2651	Inlay, resin-based composite, two surfaces	$140.00*	
D2652	Inlay, resin-based composite, three or more surfaces	$158.00*	
D2662	Onlay, resin-based composite, two surfaces	$158.00*	
D2663	Onlay, resin-based composite, three surfaces	$166.00*	
D2664	Onlay, resin-based composite, four or more surfaces	$175.00*	
D2710	Crown, resin-based composite (indirect)	$120.00*	
D2712	Crown, ¾ resin-based composite (indirect)	$123.00*	
D2720	Crown, resin with high noble metal	$175.00*	
D2721	Crown, resin with predominantly base metal	$175.00*	
D2722	Crown, resin with noble metal	$175.00*	
D2740	Crown, porcelain/ceramic	$175.00*	
D2750	Crown, porcelain fused to high noble metal	$185.00*	
D2751	Crown, porcelain fused to predominantly base metal	$185.00*	
D2752	Crown, porcelain fused to noble metal	$185.00*	
D2753	Crown, porcelain fused to titanium and titanium alloys	$185.00*	
D2780	Crown, ¾ cast high noble metal	$185.00*	
D2781	Crown, ¾ cast predominantly base metal	$185.00	
D2782	Crown, ¾ cast noble metal	$185.00*	
D2783	Crown, ¾ porcelain/ceramic	$185.00*	
D2790	Crown, full cast high noble metal	$175.00*	
D2791	Crown, full cast predominantly base metal	$175.00	
D2792	Crown, full cast noble metal	$175.00*	
D2794	Crown, titanium and titanium alloys	$175.00*	
D2799	Interim crown	$70.00	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$0.00	

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
	Restorative Services (continued)		
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	$5.00	
D2920	Re-cement or re-bond crown	$0.00	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	$40.00	
D2930	Prefabricated stainless steel crown, primary tooth	$40.00	
D2931	Prefabricated stainless steel crown, permanent tooth	$60.00	
D2932	Prefabricated resin crown	$15.00	
D2933	Prefabricated stainless steel crown with resin window	$45.00	
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	$45.00	
D2940	Placement of interim direct restoration	$0.00	
D2950	Core buildup, including any pins when required	$45.00	
D2951	Pin retention, per tooth, in addition to restoration	$8.00	
D2952	Post and core in addition to crown, indirectly fabricated	$45.00	
D2953	Each additional indirectly fabricated post, same tooth	$20.00	
D2954	Prefabricated post and core in addition to crown	$45.00	
D2955	Post removal	$18.00	
D2956	Removal of an indirect restoration on a natural tooth	$0.00	Inclusive with D2510-D2799, D2910, D2915, D2920, D2921-D2934, D2960-D2962. 1 per tooth every 5 year period, covered for members age 16 and over
D2957	Each additional prefabricated post, same tooth	$20.00	
D2960	Labial veneer (resin laminate), direct	$200.00	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D2961	Labial veneer (resin laminate), indirect	$325.00	
D2962	Labial veneer (porcelain laminate), indirect	$500.00	
D2971	Additional procedure to customize new crown, existing partial denture frame	$28.00	
D2976	Band stabilization, per tooth	$0.00	Inclusive with D2160, D2161, D2393, D2394
D2980	Crown repair necessitated by restorative material failure	$28.00	
	Endodontic Services		
D3110	Pulp cap, direct (excluding final restoration)	$0.00	
D3120	Pulp cap, indirect (excluding final restoration)	$0.00	
D3220	Therapeutic pulpotomy (excluding final restoration)	$12.00	
D3221	Pulpal debridement, primary and permanent teeth	$10.00	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$0.00	
D3240	Pulpal therapy, posterior, primary tooth (excluding final restoration)	$0.00	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$40.00	
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$48.00	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$62.00	
D3331	Treatment of root canal obstruction; non-surgical access	$192.00	
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	$70.00	
D3333	Internal root repair of perforation defects	$96.00	
D3346	Retreatment of previous root canal therapy, anterior	$40.00	
D3347	Retreatment of previous root canal therapy, premolar	$48.00	
D3348	Retreatment of previous root canal therapy, molar	$62.00	
D3351	Apexification/recalcification, initial visit	$70.00	
D3352	Apexification/recalcification, interim medication replacement	$70.00	
D3353	Apexification/recalcification, final visit	$70.00	
D3410	Apicoectomy, anterior	$45.00	
D3421	Apicoectomy, premolar (first root)	$45.00	
D3425	Apicoectomy, molar (first root)	$45.00	
D3426	Apicoectomy, (each additional root)	$20.00	
D3430	Retrograde filling, per root	$15.00	
D3450	Root amputation, per root	$15.00	
D3910	Surgical procedure for isolation of tooth with rubber dam	$17.00	
D3920	Hemisection, not including root canal therapy	$35.00	
D3950	Canal preparation and fitting of preformed dowel or post	$0.00	
	Periodontal Services		
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$35.00	1 of (D4210-D4285) per site/quad every 36 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$10.00	
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	$0.00	
D4240	Gingival flap procedure, four or more teeth per quadrant	$0.00	
D4241	Gingival flap procedure, one to three teeth per quadrant	$0.00	
D4245	Apically positioned flap	$96.00	
D4249	Clinical crown lengthening, hard tissue	$195.00	
D4260	Osseous surgery, four or more teeth per quadrant	$65.00	
D4261	Osseous surgery, one to three teeth per quadrant	$65.00	
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	$135.00	
D4264	Bone replacement graft, retained natural tooth, each additional site	$70.00	
D4270	Pedicle soft tissue graft procedure	$236.00	
D4273	Autogenous connective tissue graft procedure, first tooth	$236.00	
D4274	Mesial/distal wedge procedure, single tooth	$140.00	
D4275	Non-autogenous connective tissue graft, first tooth	$236.00	
D4277	Free soft tissue graft, first tooth	$236.00	
D4278	Free soft tissue graft, each additional tooth	$236.00	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	$236.00	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	$236.00	

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LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
	Periodontal Services (continued)		
D4322	Splint, intra-coronal; natural teeth or prosthetic crowns	$80.00	
D4323	Splint, extra-coronal; natural teeth or prosthetic crowns	$80.00	
GUIDELINE: No more than two (2) quadrants of periodontal scaling and root planing per appointment/ per day are allowable.			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$12.00	1 of (D4341, D4342) per site quad, every 24 month
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$12.00	
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$0.00	1 of (D1110, D1120, D4346) every 6 months
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	$8.00	1 (D4355) every 24 months
D4381	Localized delivery of antimicrobial agent/per tooth	$25.00	
D4910	Periodontal maintenance	$10.00	
D4920	Unscheduled dressing change (other than treating dentist or staff)	$10.00	
	Removable Prosthodontic Services		
D5110	Complete denture, maxillary	$250.00	1 of (D5110-D5283, D5877, D5878) per arch every 5 year period, if the appliance cannot be made functional through reline or repair
D5120	Complete denture, mandibular	$250.00	
D5130	Immediate denture, maxillary	$250.00	
D5140	Immediate denture, mandibular	$250.00	
D5211	Maxillary partial denture, resin base	$205.00	
D5212	Mandibular partial denture, resin base	$205.00	
D5213	Maxillary partial denture, cast metal, resin base	$235.00	
D5214	Mandibular partial denture, cast metal, resin base	$235.00	
D5221	Immediate maxillary partial denture, resin base	$205.00	
D5222	Immediate mandibular partial denture, resin base	$205.00	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	$235.00	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	$235.00	
D5225	Maxillary partial denture, flexible base	$300.00	
D5226	Mandibular partial denture, flexible base	$300.00	
D5227	Immediate maxillary partial denture, flexible base	$300.00	
D5228	Immediate mandibular partial denture, flexible base	$300.00	
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	$132.00	
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	$132.00	
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	$132.00	1 of (D5284, D5286) per site every 5 year period, if the appliance cannot be made function through reline or repair
D5286	Removable unilateral partial denture, one piece resin, per quadrant	$132.00	
D5410	Adjust complete denture, maxillary	$0.00	
D5411	Adjust complete denture, mandibular	$0.00	
D5421	Adjust partial denture, maxillary	$0.00	
D5422	Adjust partial denture, mandibular	$0.00	
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, per tooth	$18.00	
D5611	Repair resin partial denture base, mandibular	$25.00	
D5612	Repair resin partial denture base, maxillary	$25.00	
D5621	Repair cast partial framework, mandibular	$30.00	
D5622	Repair cast partial framework, maxillary	$30.00	
D5630	Repair or replace broken retentive clasping materials, per tooth	$35.00	
D5640	Replace missing or broken teeth, partial denture, per tooth	$35.00	
D5650	Add tooth to existing partial denture, per tooth	$30.00	
D5660	Add clasp to existing partial denture, per tooth	$30.00	
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	$45.00	
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	$45.00	
D5710	Rebase complete maxillary denture	$0.00	
D5711	Rebase complete mandibular denture	$0.00	
D5720	Rebase maxillary partial denture	$0.00	
D5721	Rebase mandibular partial denture	$0.00	
D5725	Rebase hybrid prosthesis	$0.00	
D5730	Reline complete maxillary denture, direct	$60.00	2 of (D5730-D5761) per arch every 12 months
D5731	Reline complete mandibular denture, direct	$60.00	
D5740	Reline maxillary partial denture, direct	$60.00	
D5741	Reline mandibular partial denture, direct	$60.00	
D5750	Reline complete maxillary denture, indirect	$75.00	
D5751	Reline complete mandibular denture, indirect	$75.00	
D5760	Reline maxillary partial denture, indirect	$75.00	
D5761	Reline mandibular partial denture, indirect	$75.00	
D5765	Soft liner for complete or partial removable denture, indirect	$60.00	
D5810	Interim complete denture, maxillary	$100.00	1 of (D5810-D5821) per arch every 5 year period
D5811	Interim complete denture, mandibular	$100.00	
D5820	Interim partial denture, maxillary	$0.00	
D5821	Interim partial denture, mandibular	$0.00	
D5851	Tissue conditioning, mandibular	$25.00	
D5850	Tissue conditioning, maxillary	$25.00	
D5877	Duplication of complete denture, maxillary	$125.00	1 of (D5110-D5283, D5877, D5878) per arch every 5 year period, if the appliance cannot be made functional through reline or repair
D5878	Duplication of complete denture, mandibular	$125.00	

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LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
GUIDELINE: Implants and all services associated with implants are listed at the actual member co-payment amount. No additional fee is allowable for porcelain, noble metal, high noble metal, or titanium for implants and procedures associated with implants.			
	Implant Services		
D6010	Surgical placement of implant body, endosteal	$2,000.00	
D6049	Scaling and debridement in the presence of peri-implantitis inflammation of a single implant	$0.00	1 of (D6049, D6081, D6180) per implant every 12 months
D6056	Prefabricated abutment, includes modification and placement	$210.00	
D6058	Abutment supported porcelain/ceramic crown	$1,110.00	
D6059	Abutment supported porcelain fused to high noble crown	$1,096.00	
D6060	Abutment supported porcelain fused to base metal crown	$1,035.00	
D6061	Abutment supported porcelain fused to noble metal crown	$1,056.00	
D6062	Abutment supported cast metal crown, high noble	$1,003.00	
D6063	Abutment supported cast metal crown, base metal	$861.00	
D6064	Abutment supported cast metal crown, noble metal	$912.00	
D6065	Implant supported porcelain/ceramic crown	$1,040.00	
D6066	Implant supported crown, porcelain fused to high noble alloys	$1,013.00	
D6067	Implant supported crown, high noble alloys	$984.00	
D6068	Abutment supported retainer, porcelain/ceramic FPD	$1,110.00	
D6069	Abutment supported retainer, metal FPD, high noble	$1,096.00	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$1,035.00	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	$1,056.00	
D6072	Abutment supported retainer, cast metal FPD, high noble	$1,028.00	
D6073	Abutment supported retainer, cast metal FPD, base metal	$930.00	
D6074	Abutment supported retainer, cast metal FPD, noble	$1,005.00	
D6075	Implant supported retainer for ceramic FPD	$1,092.00	
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	$1,064.00	
D6077	Implant supported retainer for metal FPD, high noble alloys	$984.00	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	$0.00	1 of (D6049, D6081, D6180) per implant every 12 months
D6082	Implant supported crown, porcelain fused to predominantly base alloys	$984.00	
D6083	Implant supported crown, porcelain fused to noble alloys	$984.00	
D6084	Implant supported crown, porcelain fused to titanium and titanium alloys	$984.00	
D6085	Interim implant crown	$70.00	
D6086	Implant supported crown, predominantly base alloys	$984.00	
D6087	Implant supported crown, noble alloys	$984.00	
D6088	Implant supported crown, titanium and titanium alloys	$984.00	
D6089	Accessing and retorquing loose implant screw, per screw	$0.00	Inclusive with D6096
D6092	Re-cement or re-bond implant/abutment supported crown	$45.00	
D6093	Re-cement or re-bond implant/abutment supported FPD	$65.00	
D6094	Abutment supported crown, titanium, and titanium alloys	$670.00	
D6096	Remove broken implant retaining screw	$75.00	
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	$984.00	
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	$984.00	
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	$984.00	
D6105	Removal of implant body not requiring bone removal or flap elevation	$8.00	
D6120	Implant supported retainer, porcelain fused to titanium and titanium alloys	$984.00	
D6121	Implant supported retainer for metal FPD, predominantly base alloys	$984.00	
D6122	Implant supported retainer for metal FPD, noble alloys	$984.00	
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	$984.00	
D6180	Implant maintenance procedures, full arch fixed hybrid prosthesis is not removed, including cleansing	$0.00	1 of (D6049, D6081, D6180) per implant every 12 months
D6194	Abutment supported retainer crown for FPD titanium, titanium and titanium alloys	$670.00	
D6195	Abutment supported retainer, porcelain fused to titanium and titanium alloys	$984.00	
D6196	Removal of an indirect restoration on an implant retained abutment	$0.00	
D6197	Replacement of restorative material, close access opening of screw-retained implant supported prosthesis, per implant	$55.00	1 (D6197) every 6 months, per implant
	Fixed Prosthodontic Services		
***GUIDELINES for Pontics, Retainer Crowns, Retainer Inlays, Retainer Onlays:** **The total maximum amount chargeable to the member for elective upgraded procedures** (explained below) is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure. **1. Brand name restorations:** (e.g. Sunrise, Captek, Vitadure-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits. **2. Benefits for anterior and bicuspid teeth:** Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure. **3. Benefits for molar teeth:** Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure. **4. Base metal is the benefit:** If elected, a)noble, b)high noble metal, or c) titanium may be considered an elective upgraded procedure.			
D6205	Pontic, indirect resin based composite	$145.00*	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D6210	Pontic, cast high noble metal	$145.00*	
D6211	Pontic, cast predominantly base metal	$145.00	
D6212	Pontic, cast noble metal	$145.00*	
D6214	Pontic, titanium, and titanium alloys	$145.00*	
D6240	Pontic, porcelain fused to high noble metal	$145.00*	

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
	Fixed Prosthodontic Services (continued)		
D6241	Pontic, porcelain fused to predominantly base metal	$145.00*	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D6242	Pontic, porcelain fused to noble metal	$145.00*	
D6243	Pontic, porcelain fused to titanium and titanium alloys	$145.00*	
D6245	Pontic, porcelain/ceramic	$100.00*	
D6250	Pontic, resin with high noble metal	$185.00*	
D6251	Pontic, resin with predominantly base metal	$185.00*	
D6252	Pontic, resin with noble metal	$185.00*	
D6253	Interim pontic	$122.00	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	$90.00*	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	$90.00*	
D6549	Resin retainer, for resin bonded fixed prosthesis	$90.00	
D6600	Retainer inlay, porcelain/ceramic, two surfaces	$150.00*	
D6601	Retainer inlay, porcelain/ceramic, three or more surfaces	$160.00*	
D6602	Retainer inlay, cast high noble metal, two surfaces	$150.00*	
D6603	Retainer inlay, cast high noble metal, three or more surfaces	$160.00*	
D6604	Retainer inlay, cast base metal, two surfaces	$150.00	
D6605	Retainer inlay, cast base metal, three or more surfaces	$160.00	
D6606	Retainer inlay, cast noble metal, two surfaces	$140.00*	
D6607	Retainer inlay, cast noble metal, three or more surfaces	$160.00*	
D6608	Retainer onlay, porcelain/ceramic, two surfaces	$166.00*	
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	$175.00*	
D6610	Retainer onlay, cast high noble metal, two surfaces	$160.00*	
D6611	Retainer onlay, cast high noble metal, three or more surfaces	$166.00*	
D6612	Retainer onlay, cast base metal, two surfaces	$160.00	
D6613	Retainer onlay, cast base metal, three or more surfaces	$166.00	
D6614	Retainer onlay, cast noble metal, two surfaces	$160.00*	
D6615	Retainer onlay, cast noble metal three or more surfaces	$166.00*	
D6624	Retainer inlay, titanium	$160.00*	
D6634	Retainer onlay, titanium	$166.00*	
D6710	Retainer crown, indirect resin based composite	$88.00*	
D6720	Retainer crown, resin with high noble metal	$100.00*	
D6721	Retainer crown, resin with predominantly base metal	$100.00*	
D6722	Retainer crown, resin with noble metal	$100.00*	
D6740	Retainer crown, porcelain/ceramic	$145.00*	
D6750	Retainer crown, porcelain fused to high noble metal	$185.00*	
D6751	Retainer crown, porcelain fused to predominantly base metal	$185.00*	
D6752	Retainer crown, porcelain fused to noble metal	$185.00*	
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	$185.00*	
D6780	Retainer crown, ¾ cast high noble metal	$185.00*	
D6781	Retainer crown, ¾ cast predominantly base metal	$185.00	
D6782	Retainer crown, ¾ cast noble metal	$185.00*	
D6783	Retainer crown, ¾ porcelain/ceramic	$175.00*	
D6784	Retainer crown ¾, titanium and titanium alloys	$185.00*	
D6790	Retainer crown, full cast high noble metal	$145.00*	
D6791	Retainer crown, full cast predominantly base metal	$145.00	
D6792	Retainer crown, full cast noble metal	$145.00*	
D6793	Interim retainer crown	$70.00	
D6794	Retainer crown, titanium and titanium alloys	$145.00*	1 of (D2510-D2794, D2960-D2962, D6205-D6252, D6545-D6792, D6794) per tooth every 5 year period, covered for members age 16 and over
D6930	Re-cement or re-bond fixed partial denture	$0.00	
D6940	Stress breaker	$25.00	
D6980	Fixed partial denture repair, restorative material failure	$30.00	
	Oral & Maxillofacial Services		
D7111	Extraction, coronal remnants, primary tooth	$5.00	
D7140	Extraction, erupted tooth or exposed root	$8.00	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$15.00	
D7220	Removal of impacted tooth, soft tissue	$20.00	
D7230	Removal of impacted tooth, partially bony	$24.00	
D7240	Removal of impacted tooth, completely bony	$28.00	
D7241	Removal impacted tooth, complete bony, complication	$28.00	
D7250	Removal of residual tooth roots (cutting procedure)	$0.00	
D7259	Nerve dissection	$0.00	1 (D7259) per tooth in a lifetime; limited to teeth #17 and #32. Inclusive with D7241. Must be performed by licensed Oral Surgeon.
D7261	Primary closure of a sinus perforation	$170.00	
D7270	Tooth reimplantation and/or stabilization, accident	$160.00	
D7280	Exposure of an unerupted tooth	$80.00	
D7282	Mobilization of erupted/malpositioned tooth	$55.00	
D7283	Placement, device to facilitate eruption, impaction	$55.00	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	$0.00	
D7286	Incisional biopsy of oral tissue, soft	$0.00	
D7287	Exfoliative cytological sample collection	$10.00	
D7288	Brush biopsy, transepithelial sample collection	$10.00	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$50.00	

LIBERTY Dental Plan of California, Inc.

LDP-600 Plan Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

CDT Code	Description	Member Co-payment	Frequency
	Oral & Maxillofacial Services (continued)		
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$50.00	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$50.00	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$50.00	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	$70.00	
D7350	Vestibuloplasty, ridge extension	$100.00	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	$80.00	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	$160.00	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	$90.00	
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	$125.00	
D7471	Removal of lateral exostosis, maxilla or mandible	$96.00	
D7472	Removal of torus palatinus	$70.00	
D7473	Removal of torus mandibularis	$70.00	
D7485	Reduction of osseous tuberosity	$50.00	
D7509	Marsupialization of odontogenic cyst	$0.00	
D7510	Incision & drainage of abscess, intraoral soft tissue	$15.00	
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	$20.00	
D7520	Incision & drainage of abscess, extraoral soft tissue	$15.00	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	$20.00	
D7530	Remove foreign body, mucosa, skin, tissue	$18.00	
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$45.00	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	$0.00	
D7961	Buccal/labial frenectomy (frenulectomy)	$25.00	
D7962	Lingual frenectomy (frenulectomy)	$25.00	
D7963	Frenuloplasty	$25.00	
D7970	Excision of hyperplastic tissue, per arch	$40.00	
D7971	Excision of pericoronal gingiva	$35.00	
D7993	Surgical placement of craniofacial implant, extra oral	$2,000.00	
D7994	Surgical placement: zygomatic implant	$2,000.00	
	Adjunctive General Services		
D9110	Palliative treatment of dental pain, per visit	$18.00	
D9120	Fixed partial denture sectioning	$5.00	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	$0.00	
D9211	Regional block anesthesia	$0.00	
D9212	Trigeminal division block anesthesia	$0.00	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0.00	
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0.00	
**GUIDELINE: Deep sedation/general anesthesia is a covered benefit only when in conjunction with covered oral surgery and pedodontic procedures when dispensed in a dental office by a practitioner acting within the scope of his/her licensure; and when warranted by documented conditions that local anesthetic and contraindicated. General anesthesia, as used for dental pain control, means the elimination of all sensations accompanied by a state of unconsciousness. Patient apprehension and/or nervousness are not of themselves sufficient justification for deep sedation/general anesthesia or intravenous conscious sedation/analgesia.			
D9222	Administration of deep sedation/general anesthesia, first 15 minute increment, or any portion thereof	$125.00**	
D9223	Administration of deep sedation/general anesthesia, each subsequent 15 minute increment, or any portion thereof	$125.00**	
D9224	Administration of general anesthesia with advanced airway, first 15 minute increment, or any portion thereof	$125.00**	
D9225	Administration of general anesthesia with advanced airway, each subsequent 15 minute increment, or any portion thereof	$125.00**	
D9230	Administration of nitrous oxide	$35.00	
D9239	Administration of moderate sedation, intravenous, first 15 minute increment, or any portion thereof	$125.00**	
D9243	Administration of moderate sedation, intravenous, each subsequent 15 minute increment, or any portion thereof	$125.00**	
D9244	In-office administration of minimal sedation, single drug, enteral	$100.00	
D9245	Administration of moderate sedation, enteral	$100.00	
D9246	Administration of moderate sedation, non-intravenous parenteral, first 15 minute increment, or any portion thereof	$100.00	
D9247	Administration of moderate sedation, non-intravenous parenteral, each subsequent 15 minute increment, or any portion thereof	$0.00	
D9310	Consultation, other than requesting dentist	$0.00	
D9311	Consultation with a medical health care professional	$0.00	
D9430	Office visit, observation, regular hours, no other services	$0.00	
D9440	Office visit, after regularly scheduled hours	$24.00	
D9450	Case presentation, subsequent, detailed, extensive treatment planning	$0.00	
D9630	Drugs or medicaments dispensed in the office for home use	$14.00	
D9910	Application of desensitizing medicament	$5.00	
D9911	Application of desensitizing resin for cervical, root surface, per tooth	$5.00	
D9912	Pre-visit patient screening	$0.00	
D9930	Treatment of complications, post surgical, unusual, by report	$10.00	
D9942	Repair and/or reline of occlusal guard	$45.00	
D9944	Occlusal guard, hard appliance, full arch	$175.00	
D9945	Occlusal guard, soft appliance, full arch	$175.00	

CDT Code	Description	Member Co-payment	Frequency
	Adjunctive General Services (continued)		
D9946	Occlusal guard, hard appliance, partial arch	$175.00	
D9950	Occlusion analysis, mounted case	$0.00	
D9951	Occlusal adjustment, limited	$15.00	
D9952	Occlusal adjustment, complete	$18.00	
D9971	Odontoplasty, per tooth	$5.00	
D9986	Missed appointment	$20.00	
D9987	Cancelled appointment	$0.00	
D9991	Dental case management, addressing appointment compliance barriers	$0.00	
D9992	Dental case management, care coordination	$0.00	
D9993	Dental case management, motivational interviewing	$0.00	
D9994	Dental case management, patient education to improve oral health literacy	$0.00	
D9997	Dental case management, patients with special health care needs	$0.00	
	Office visit, per visit	$0.00	

LIBERTY Dental Plan of California, Inc.

Schedule of Benefits

Covered Benefits, Member Co-payments, Limitations Exclusions

Limitations:

1. Fabricated crowns, onlays and inlays may be covered when a tooth with a good prognosis requires restoration but has insufficient remaining structure to reliably retain a filling. Coverage for these procedures limited to members age 16 and over.
2. Procedures that appear to have a poor prognosis as determined by a licensed LIBERTY dentist consultant are not covered.
3. Localized delivery of antimicrobial agents may be covered 4-6 weeks after the completion of scaling and root planing as an adjunctive procedure for 2 non-responsive sites in a quadrant with 5mm pockets or deeper plus inflammation.
4. For treatment plans involving 7 or more units of crowns and/or fixed partial dentures (bridges), contracted providers may charge an additional $200 co-payment per unit. In such cases, the first 6 units are covered at the specified member co-payment amount only, as documented in this Schedule of Benefits.
5. Fixed partial dentures (bridges) are covered when: replacing a “like-for-like” existing fixed partial denture with identical pontics and abutment teeth with good prognosis; abutment teeth qualify for crowns on their own merit; there is only one missing permanent tooth in a full arch and the bridge would have opposing teeth in the opposite arch.
6. Pediatric referrals, if authorized by LIBERTY, are covered only for dependent children through the age of 6 unless the child qualifies under the American with Disabilities Act (ADA).

Exclusions:

1. Any procedure not specifically listed as a Covered Benefit.
2. Replacement of lost or stolen prosthetics or appliances including partial dentures, full dentures, and orthodontic appliances.
3. General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist other than those situations described in the Schedule of Benefits (**).
4. Treatment started prior to coverage or after termination of coverage.
5. Procedures, appliances, or restorations to treat temporomandibular joint dysfunctions (e.g. adjustments/corrections to the facial bones), congenital or developmental situations (including supernumerary teeth) or medically induced dental disorders, including but not limited to: myofunctional treatment (e.g. speech therapy), or myoskeletal dysfunctions, unless otherwise covered as an orthodontic benefit.
6. Services for cosmetic purposes or for conditions that are a result of hereditary developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
7. Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice.
8. Procedures performed on natural teeth solely to increase vertical dimension or restore occlusion.
9. Any service performed outside of your assigned dental office, unless expressly authorized by LIBERTY Dental Plan, or unless as outlined and covered in the “Emergency Dental Care” section of the Evidence of Coverage.
10. The removal of asymptomatic, unerupted third molars (or other teeth) that appear to have an unimpeded pathway to eruption and no active pathology.
11. Procedures or appliances that are provided by a dentist who specializes in prosthodontic services.
12. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding occlusion or maintaining chewing surfaces or teeth that are out of alignment or for stabilizing teeth. Examples of such treatment are equilibration and periodontal splinting.
13. Any routine dental services performed by a dentist or dental specialist in an inpatient/outpatient hospital setting.
14. Consultations for non-covered services.

LIBERTY Dental Plan of California, Inc.

Ortho-275 PLAN SCHEDULE OF BENEFITS

Primary Dentition: Teeth developed and erupted first in order of time.

Transitional Dentition: The Final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

Treatment must be provided by a LIBERTY Dental Plan contracted orthodontic provider.
Any procedure not listed is available at the provider's usual and customary fee

CDT Code	Description	Member Co-payment
D0340	2D cephalometric radiographic image, measurement and analysis	$150.00
D0396	3D printing of a 3D dental surface scan	$125.00
D0470	Diagnostic casts	$125.00
D0702	2-D cephalometric radiographic image, image capture only	$150.00
D9310	Consultation, other than requesting dentist	$0.00
D8010	Limited orthodontic treatment of the primary dentition	$1,550.00
D8020	Limited orthodontic treatment of the transitional dentition	$1,550.00
D8030	Limited orthodontic treatment of the adolescent dentition	$1,550.00
D8040	Limited orthodontic treatment of the adult dentition	$1,550.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,775.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,775.00
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,950.00
D8091	Comprehensive orthodontic treatment with orthognathic surgery	$1,775.00
D8210	Removable appliance therapy	$350.00
D8220	Fixed appliance therapy	$350.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$0.00
D8670	Periodic orthodontic treatment visit	$0.00
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	$0.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$325.00
D9986	Missed appointment	$25.00
D9987	Cancelled appointment	$0.00

Orthodontic Exclusions:

1. Replacement of lost or stolen orthodontic appliances
2. Lost, stolen or broken appliances
3. Orthodontic treatment started prior to member's effective date of coverage unless covered through an orthodontic takeover provision.
4. Extractions for orthodontic purposes, (will not be applied if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition).
5. Treatment in progress at the time of eligibility, unless included as an orthodontic rider to the groups benefits.
6. Temporomandibular joint syndrome (TMJ) surgical orthodontics
7. Myofunctional therapy
8. Treatment of cleft palate
9. Treatment of micrognathia
10. Treatment of macroglossia
11. Changes in orthodontic treatment necessitated by accident of any kind.
12. Orthodontic coverage is limited to 24 months of treatment, followed by 24 months of retention office visits.
13. Services provided after the 24th month of treatment and/or retention is the responsibility of the patient at a fee not to exceed $130 per month.
14. In the event of termination the patient is responsible for the usual fee of the treating dentist pro-rated over the remainder of treatment and/or retention.

ATTACHMENT B

PREMIUMS

Subscriber Only:	**$** 13.84
Subscriber + 1 Dependent:	**$** 24.92
Subscriber + Family:	**$** 36.00