

# Group DHMO Dental

This plan is for employees located in Texas.

All Eligible Employees

Plan Design and Fees

Plan design summary

Dental Plan Overview	
Eligible Employees	All Full-Time United States Employees working in the United States who are scheduled to work a minimum of 20 hours per week
Effective date	January 1, 2026
Plan type	PREPAID DENTAL SERIES 189
Minimum participation requirement	20%
Specialty Benefit	Included
Orthodontia	Included

## Dental Fees

	Dental monthly fees
Employee	\$14.49
Employee + Spouse	\$24.20
Employee + Children	\$32.24
Employee + Family	\$42.84

Sequence Number: 4

## Included in this plan:

- Sun Life’s Dental Flat Percent broker commission
- 12 month fee guarantee from the Effective Date
- Minimum participation requirements of 5 enrolled employees per state

# PREPAID DENTAL SERIES 189 PLAN

## Sample Copayment Schedule

### 1. Plan Provider Services

The dental services listed in the following schedule are covered when provided by the Member's selected Plan Dentist. If Member requires dental specialty services that cannot be provided by selected Plan Dentist, Member may obtain from a Plan Specialty Dentist the services marked as dental specialty services (S) in this Section 1. No referral from Member's selected Plan Dentist is needed to receive services from a Plan Specialty Dentist. The Member will be responsible for paying the amount listed in the "Member Copayment" column (plus any applicable lab fees (\*)) at the time the service is received, or in accordance with the Plan Provider's billing procedures.

Dental services obtained from a Plan Specialty Dentist that are not listed and marked as dental specialty services (S) in this Section 1 or listed in Section 2 below will be provided to Member at reduced charges. A 15% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from a Plan Specialty Dentist whose practice is limited to endodontics. A 25% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from any other Plan Specialty Dentist (including, but not limited to, a Plan Specialty Dentist whose practice is orthodontics). Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

To fully understand the benefits, exclusions and limitations of this plan, the Member should consult the Evidence of Coverage. The Plan Provider is permitted to charge the member for any missed appointments if the Member fails to give at least 24 hours notice. The charge may not exceed \$20.00.

Services marked with a single asterisk (\*) below also require separate payment of laboratory charges. The laboratory charges must be paid to the Plan Provider in addition to any applicable copayment for the service.

*Payment for each service of a Non-Plan Dentist (at that dentist's normal retail charge) is the responsibility of the Member, except for Plan Benefits for covered dental Emergency Services.*

ADA Code**	Service Description**	Member Copayment
<b>Appointments</b>		
None	Office visit - during regularly scheduled hours***	No Charge
D0120	Periodic oral evaluation - established patient (ADA Code D0120 may only be obtained once in any six calendar months, except for medically necessary more frequent evaluations as determined by Member's Plan Dentist.)†	No Charge
D0140	Limited oral evaluation - problem focused.....	No Charge
D0150	Comprehensive oral evaluation - new or established patient (ADA Code D0150 may only be obtained once in any six calendar months, except for medically necessary more frequent evaluations as determined by Member's Plan Dentist.)†	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report.....	No Charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).....	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient.....	No Charge
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.....	55.00
D9440	Office visit - after regularly scheduled hours.....	30.00
<b>Diagnostic Dentistry</b>		
D0210	Intraoral - comprehensive series of radiographic images (ADA Code D0210 may only be obtained once in any three calendar years, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.)†	No Charge
D0220	Intraoral-periapical first radiographic image.....	No Charge
D0230	Intraoral-periapical each additional radiographic image.....	No Charge
D0240	Intraoral-occlusal radiographic image.....	No Charge
D0250	Extraoral-2D projection radiographic image created using a stationary radiation source, and detector.....	No Charge

ADA Code**	Service Description**	Member Copayment
D0260	Extraoral-each additional radiographic image.....	No Charge
D0270	Bitewing-single radiographic image.....	No Charge
D0272	Bitewing-two radiographic images (ADA Code D0272 may only be obtained once in any six calendar months, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.)†.....	No Charge
D0274	Bitewing-four radiographic images (ADA Code D0274 may only be obtained once in any six calendar months, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.)†.....	No Charge
D0277	Vertical bitewings-7 to 8 radiographic images.....	No Charge
D0330	Panoramic radiographic image (ADA Code D0330 may only be obtained once in any three calendar years, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.)†.....	No Charge
D0415	Collection of microorganisms for culture and sensitivity.....	No Charge
D0425	Caries susceptibility tests.....	No Charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures.....	40.00
D0460	Pulp vitality tests.....	No Charge
<b>Preventive Dentistry</b>		
D1110	Prophylaxis - adult (ADA Code D1110 may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist.).....	No Charge
D1120	Prophylaxis - child (ADA Code D1120 may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist.).....	No Charge
D1206	Topical application of fluoride varnish.....	No Charge
D1310	Nutritional counseling for control of dental disease.....	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease.....	No Charge
D1330	Oral hygiene instructions.....	No Charge
D1351	Sealant - per tooth.....	No Charge
D1510	Space maintainer - fixed - unilateral*.....	50.00
D1516	Space maintainer - fixed - bilateral, maxillary*.....	50.00
D1517	Space maintainer - fixed - bilateral, mandibular*.....	50.00
D1520	Space maintainer - removable - unilateral*.....	65.00
D1526	Space maintainer - removable - bilateral, maxillary*.....	90.00
D1527	Space maintainer - removable - bilateral, mandibular*.....	90.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary.....	10.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular.....	10.00
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant.....	10.00
None	Additional prophylaxis***.....	40.00
D9944	Occlusal guard - hard appliance, full arch*.....	85.00
D9945	Occlusal guard - soft appliance, full arch*.....	85.00
D9946	Occlusal guard - hard appliance, partial arch*.....	85.00
D9951	Occlusal adjustment - limited.....	15.00
D9952	Occlusal adjustment - complete.....	55.00
<b>Restorative Dentistry</b>		
D2140	Amalgam - one surface, primary or permanent.....	5.00
D2150	Amalgam - two surfaces, primary or permanent.....	10.00
D2160	Amalgam - three surfaces, primary or permanent.....	15.00
D2161	Amalgam - four or more surfaces, primary or permanent.....	15.00
D2330	Resin-based composite - one surface, anterior.....	20.00



ADA Code**	Service Description**	Member Copayment
D2331	Resin-based composite - two surfaces, anterior.....	30.00
D2332	Resin-based composite - three surfaces, anterior.....	45.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).....	65.00
D2391	Resin-based composite - one surface, posterior.....	50.00
D2392	Resin-based composite - two surfaces, posterior.....	60.00
D2393	Resin-based composite - three surfaces, posterior.....	70.00
D2394	Resin-based composite - four or more surfaces, posterior.....	95.00
D2510	Inlay - metallic - one surface*.....	75.00
D2520	Inlay - metallic - two surfaces*.....	85.00
D2530	Inlay - metallic - three or more surfaces*.....	110.00
D2542	Onlay - metallic - two surfaces*.....	100.00
D2543	Onlay - metallic - three surfaces*.....	120.00
D2544	Onlay - metallic - four or more surfaces*.....	130.00
D2610	Inlay - porcelain/ceramic one surface*.....	200.00
D2620	Inlay - porcelain/ceramic two surfaces*.....	210.00
D2630	Inlay - porcelain/ceramic three or more surfaces*.....	220.00
D2740	Crown - porcelain/ceramic*.....	189.00
D2750	Crown - porcelain fused to high noble metal*.....	189.00
D2751	Crown - porcelain fused to predominantly base metal*.....	189.00
D2752	Crown - porcelain fused to noble metal*.....	189.00
D2790	Crown - full cast high noble metal*.....	189.00
D2791	Crown - full cast predominantly base metal*.....	189.00
D2792	Crown - full cast noble metal*.....	189.00
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration.....	15.00
D2920	Re-cement or re-bond crown.....	15.00
D2930	Prefabricated stainless steel crown - primary tooth.....	80.00
D2932	Prefabricated resin crown.....	35.00
D2933	Prefabricated stainless steel crown with resin window.....	45.00
D2940	Protective restoration.....	15.00
D2950	Core buildup, including any pins.....	75.00
D2951	Pin retention - per tooth, in addition to restoration.....	15.00
D2952	Post and core in addition to crown, indirectly fabricated*.....	90.00
D2953	Each additional indirectly fabricated post - same tooth*.....	45.00
D2954	Prefabricated post and core in addition to crown.....	80.00
D2955	Post removal.....	25.00
D2957	Each additional prefabricated post - same tooth.....	30.00
D2971	Additional procedures to customize construct a new crown to fit under an existing partial denture framework*.....	55.00
D2980	Crown repair necessitated by restorative material failure*.....	25.00
None	Temporary filling***.....	15.00
<b>Endodontics</b>		
D3110	Pulp cap - direct (excluding final restoration).....	15.00
D3120	Pulp cap - indirect (excluding final restoration).....	10.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.....	40.00
D3221	Pulpal debridement, primary and permanent teeth.....	50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).....	50.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration).....	95.00

ADA Code**	Service Description**	Member Copayment
D3320	Endodontic therapy, premolar tooth (excluding final restoration) <sup>(S)</sup> .....	200.00
D3330	Endodontic therapy, molar (excluding final restoration) <sup>(S)</sup> .....	225.00
D3331	Treatment of root canal obstruction, non-surgical access.....	70.00
D3332	Incomplete endodontic therapy, inoperable, unrestorable or fractured tooth.....	150.00
D3333	Internal root repair of perforation defects.....	100.00
D3346	Retreatment of previous root canal therapy - anterior <sup>(S)</sup> .....	300.00
D3347	Retreatment of previous root canal therapy - premolar <sup>(S)</sup> .....	390.00
D3348	Retreatment of previous root canal therapy - molar <sup>(S)</sup> .....	460.00
D3351	Apexification/recalcification - initial visit (apical closure/calific repair of perforations, root resorption, etc.).....	175.00
D3352	Apexification/recalcification - interim medication replacement.....	175.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.).....	175.00
D3410	Apicoectomy - anterior <sup>(S)</sup> .....	125.00
D3421	Apicoectomy - premolar (first root) <sup>(S)</sup> .....	165.00
D3425	Apicoectomy - molar (first root) <sup>(S)</sup> .....	240.00
D3426	Apicoectomy - each additional root.....	100.00
D3430	Retrograde filling - per root <sup>(S)</sup> .....	75.00
D3450	Root amputation - per root.....	70.00
D3910	Surgical procedure for isolation of tooth with rubber dam.....	10.00
D3920	Hemisection (including any root removal), not including root canal therapy.....	80.00
D3950	Canal preparation and fitting of performed dowel or post.....	65.00
<b>Periodontics</b>		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant <sup>(S)</sup> .....	135.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant <sup>(S)</sup> .....	75.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.....	140.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.....	100.00
D4245	Apically positioned flap.....	145.00
D4249	Clinical crown lengthening - hard tissue.....	120.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant <sup>(S)</sup> .....	70.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant <sup>(S)</sup> .....	50.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant*.....	160.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant*.....	145.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site*.....	80.00
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site*.....	230.00
D4267	Guided tissue regeneration, natural teeth - non-resorbable barrier, per site.....	240.00
D4270	Pedicle soft tissue graft procedure.....	265.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.....	75.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft.....	320.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft site.....	260.00

ADA Code**	Service Description**	Member Copayment
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.....	260.00
D4322	Splint - intra-coronal; natural teeth or prosthetic crowns.....	80.00
D4323	Splint - extra-coronal; natural teeth or prosthetic crowns.....	75.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant <sup>(S)</sup> .....	75.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant <sup>(S)</sup> .....	35.00
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit <sup>(S)</sup> .....	50.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth.....	40.00
D4910	Periodontal maintenance.....	45.00
None	Additional periodontal maintenance procedures (limit 2 additional years)***.....	30.00
None	Periodontal hygiene instructions***.....	No Charge
<b>Removable Prosthodontics (Removable Dentures)</b>		
D5110	Complete denture - maxillary.....	295.00
D5120	Complete denture - mandibular.....	295.00
D5130	Immediate denture - maxillary.....	400.00
D5140	Immediate denture - mandibular.....	400.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)*.....	355.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)*.....	335.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*.....	365.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*.....	365.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)*.....	700.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)*.....	700.00
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary.....	400.00
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular.....	400.00
D5410	Adjust complete denture - maxillary.....	15.00
D5411	Adjust complete denture - mandibular.....	15.00
D5421	Adjust partial denture - maxillary.....	15.00
D5422	Adjust partial denture - mandibular.....	15.00
D5511	Repair broken complete denture base, mandibular.....	30.00
D5512	Repair broken complete denture base, maxillary.....	30.00
D5611	Repair resin partial denture base, mandibular.....	35.00
D5612	Repair resin partial denture base, maxillary.....	35.00
D5621	Repair cast partial framework, mandibular.....	35.00
D5622	Repair cast partial framework, maxillary.....	35.00
D5630	Repair or replace broken clasp - per tooth.....	35.00
D5640	Replace broken teeth - per tooth.....	35.00
D5650	Add tooth to existing partial denture.....	35.00
D5660	Add clasp to existing partial denture - per tooth.....	55.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)*.....	165.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)*.....	165.00
D5710	Rebase complete maxillary denture.....	195.00
D5711	Rebase complete mandibular denture.....	180.00
D5720	Rebase maxillary partial denture.....	150.00



ADA Code**	Service Description**	Member Copayment
D5721	Rebase mandibular partial denture*	155.00
D5730	Reline complete maxillary denture (chairside).....	60.00
D5731	Reline complete mandibular denture (chairside).....	60.00
D5740	Reline maxillary partial denture (chairside).....	60.00
D5741	Reline mandibular partial denture (chairside).....	60.00
D5750	Reline complete maxillary denture (laboratory)*.....	95.00
D5751	Reline complete mandibular denture (laboratory)*.....	95.00
D5760	Reline maxillary partial denture (laboratory)*.....	95.00
D5761	Reline mandibular partial denture (laboratory)*.....	95.00
D5810	Interim complete denture (maxillary)*.....	240.00
D5811	Interim complete denture (mandibular)*.....	240.00
D5820	Interim partial denture (maxillary)*.....	300.00
D5821	Interim partial denture (mandibular)*.....	300.00
D5850	Tissue conditioning, maxillary.....	25.00
D5851	Tissue conditioning, mandibular.....	25.00
D5862	Precision attachment, by report*.....	145.00
<b>Fixed Prosthodontics (Bridges or Fixed Partial Dentures)</b>		
D6210	Pontic - cast high noble metal*.....	189.00
D6211	Pontic - cast predominantly base metal*.....	189.00
D6212	Pontic - cast noble metal*.....	189.00
D6240	Pontic - porcelain fused to high noble metal*.....	189.00
D6241	Pontic - porcelain fused to predominantly base metal*.....	189.00
D6242	Pontic - porcelain fused to noble metal*.....	189.00
D6250	Pontic - resin with high noble metal*.....	189.00
D6251	Pontic - resin with predominantly base metal*.....	189.00
D6252	Pontic - resin with noble metal*.....	189.00
D6253	Interim pontic - further treatment or completion of diagnosis necessary prior to final impression*.....	189.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis*.....	140.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces*.....	165.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces*.....	175.00
D6602	Retainer inlay - cast high noble metal, two surfaces*.....	165.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces*.....	175.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces*.....	165.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces*.....	175.00
D6606	Retainer inlay - cast noble metal, two surfaces*.....	165.00
D6607	Retainer inlay - cast noble metal, three or more surfaces*.....	175.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces*.....	165.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces*.....	175.00
D6610	Retainer onlay - cast high noble metal, two surfaces*.....	165.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces*.....	175.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces*.....	165.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces*.....	175.00
D6614	Retainer onlay - cast noble metal, two surfaces*.....	165.00
D6615	Retainer onlay - cast noble metal, three or more surfaces*.....	175.00
D6710	Retainer crown - indirect resin based composite*.....	100.00
D6720	Retainer crown - resin with high noble metal*.....	189.00
D6721	Retainer crown - resin with predominantly base metal*.....	189.00

ADA Code**	Service Description**	Member Copayment
D6722	Retainer crown - resin with noble metal'	189.00
D6740	Retainer crown - porcelain/ceramic'	189.00
D6750	Retainer crown - porcelain fused to high noble metal'	189.00
D6751	Retainer crown - porcelain fused to predominantly base metal'	189.00
D6752	Retainer crown - porcelain fused to noble metal'	189.00
D6780	Retainer crown - 3/4 cast high noble metal'	189.00
D6781	Retainer crown - 3/4 cast predominantly base metal.	170.00
D6782	Retainer crown - 3/4 cast noble metal.	170.00
D6783	Retainer crown - 3/4 porcelain/ceramic'	170.00
D6790	Retainer crown - full cast high noble metal'	189.00
D6791	Retainer crown - full cast predominantly base metal'	189.00
D6792	Retainer crown - full cast noble metal'	189.00
D6794	Retainer crown - titanium'	225.00
D6930	Re-cement or re-bond fixed partial denture.	15.00
D6940	Stress breaker.	150.00
D6950	Precision attachment.	195.00
D6980	Fixed partial denture repair, by report'	45.00
D9120	Fixed partial denture sectioning.	65.00
None	Resin bonded bridge pontic, per unit'(***)	235.00
<b>Oral Surgery</b>		
D7111	Extraction, coronal remnants - primary tooth.	15.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	15.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated <sup>(S)</sup> .	60.00
D7220	Removal of impacted tooth - soft tissue <sup>(S)</sup> .	70.00
D7230	Removal of impacted tooth - partially bony <sup>(S)</sup> .	85.00
D7240	Removal of impacted tooth - completely bony <sup>(S)</sup> .	125.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications <sup>(S)</sup> .	150.00
D7250	Removal of residual tooth roots (cutting procedure) <sup>(S)</sup> .	40.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	100.00
D7280	Exposure of an erupted tooth.	165.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	90.00
D7283	Placement of device to facilitate eruption of impacted tooth'.	70.00
D7285	Biopsy of oral tissue - hard (bone, tooth).	70.00
D7286	Biopsy of oral tissue - soft.	20.00
D7287	Exfoliative cytological sample collection.	45.00
D7288	Brush biopsy - transepithelial sample collection.	45.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant <sup>(S)</sup> .	70.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	80.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant <sup>(S)</sup> .	90.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	20.00
D7471	Removal of lateral exostosis (maxilla or mandible).	75.00
D7472	Removal of torus palatinus.	55.00
D7473	Removal of torus mandibularis.	55.00
D7485	Reduction of osseous tuberosity.	55.00
D7510	Incision and drainage of abscess - intraoral soft tissue <sup>(S)</sup> .	35.00



ADA Code**	Service Description**	Member Copayment
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces).....	40.00
D7520	Incision and drainage of abscess - extraoral soft tissue.....	40.00
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces).....	40.00
D7910	Suture of recent small wounds up to 5 cm.....	35.00
D7961	Buccal/labial frenectomy (frenulectomy) <sup>(S)</sup> .....	40.00
D7962	Lingual frenectomy (frenulectomy) <sup>(S)</sup> .....	40.00
D7963	Frenuloplasty.....	50.00
D7970	Excision of hyperplastic tissue - per arch.....	60.00
D7971	Excision of pericoronal gingiva.....	60.00
<b>Emergency Treatment of Pain</b>		
D9110	Palliative treatment of dental pain - per visit.....	25.00
<b>Anesthesia, Analgesia, and Sedation</b>		
D9222	Deep sedation/general anesthesia - first 15 minutes.....	130.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide.....	20.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes <sup>(S)</sup> .....	100.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment <sup>(S)</sup> .....	30.00
D9248	Non-intravenous (conscious) sedation.....	15.00
D9610	Therapeutic parenteral drug, single administration*.....	20.00
D9612	Therapeutic parenteral drugs, two or more administrations, different medications*.....	35.00
D9630	Drugs or medicaments dispensed in the office for home use*.....	20.00
D9910	Application of desensitizing medicament.....	15.00

This is a sample Member Copayment Schedule only. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement, Evidence of Coverage, and Copayment Schedule, which determine all rights, benefits, and applicable limitations and exclusions.

Listed copayments apply only to Plan Providers who perform the corresponding listed services. The Plan Dentist selected by the Member may not perform all listed services. Plan Specialty Dentist may not perform or offer all services listed. Availability and participation of Plan Dentists and Plan Specialty Dentist are subject to change.

(S) – Plan Benefits are available for these services when they are provided by a Plan Specialty Dentist.

\*\* Current and prior versions of the Current Dental Terminology (CDT) codes (in the **ADA Code** column) and descriptors (in the **Service Description** column) are copyrighted by the American Dental Association (ADA) and are used by permission. Current Dental Terminology © 2022 American Dental Association. All rights reserved.

\*\*\* Service does not have an American Dental Association Current Dental Terminology code or descriptor.

‡More often if medically necessary as determined by attending Plan Dentist.

## 2. Orthodontia Services

The dental services listed in the following schedule are covered when provided by a Plan Specialty Dentist. Member is responsible for paying the amount in the Member Copayment column either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

ADA Code**	Service Description**	Member Copayment
<b>Orthodontics</b>		
None	Bracketing (for D8070, D8080 or D8090) <sup>***</sup> .....	300.00
D8070	Comprehensive orthodontic treatment of the transitional dentition.....	2000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition (under 19 years).....	2000.00

ADA Code**	Service Description**	Member Copayment
D8090	Comprehensive orthodontic treatment of the adult dentition (19 years or older).....	2200.00
D8660	Pre-orthodontic treatment examination to monitor growth and development (consult/records/exam).....	100.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)).....	250.00

The Orthodontic Copayments listed above only apply during the first 24 months of active treatment and are only available once per lifetime. After 24 months of active treatment, the above Orthodontic Copayments are no longer applicable, and the listed services will be provided to Member at a 25% reduction from the Plan Specialty Dentist's normal retail charge. Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

This is a sample schedule only. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement, Evidence of Coverage, and Copayment Schedule, which determine all rights, benefits, and applicable limitations and exclusions.

Listed copayments apply only to Plan Specialty Dentists who perform the corresponding listed services. Plan Specialty Dentists may not perform or offer all services listed. Availability and participation of Specialty Dentists are subject to change.

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\*\*\*Service does not have an American Dental Association Current Dental Terminology code or descriptor.

### 3. Non-Plan Specialty Dental Services

The dental services listed in the following schedule are covered when provided by a Non-Plan Specialty Dentist. Except for benefits for medically necessary services and Emergency Services as specifically stated in the MEDICALLY NECESSARY AND EMERGENCY SERVICES Article of the Evidence of Coverage, Member is responsible for paying the Non-Plan Specialty Dentist's entire normal retail charge for the service at the time the service is received or in accordance with the Non-Plan Specialty Dentist's billing procedures. Member may then submit a completed claim form, with the itemized bill attached, to Company. (Member may obtain claim forms by contacting Company.) Company will pay Member the lesser of the amount shown in the Maximum Company Reimbursement column or the amount charged by the Non-Plan Specialty Dentist for the service. Plan Benefit payments for services by Non-Plan Specialty Dentist are limited to a total of \$2,000.00 per calendar year.

ADA Code**	Service Description**	Maximum Company Reimbursement
D3320	Endodontic therapy, premolar tooth (excluding final restoration).....	415.00
D3330	Endodontic therapy, molar (excluding final restoration).....	630.00
D3346	Retreatment of previous root canal therapy - anterior.....	280.00
D3347	Retreatment of previous root canal therapy - premolar.....	420.00
D3348	Retreatment of previous root canal therapy - molar.....	445.00
D3410	Apicoectomy - anterior.....	475.00
D3421	Apicoectomy - premolar (first root).....	530.00
D3425	Apicoectomy - molar (first root).....	495.00
D3430	Retrograde filling - per root.....	135.00
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.....	405.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.....	110.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.....	550.00



ADA Code**	Service Description**	Maximum Company Reimbursement
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.....	180.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.....	135.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant.....	110.00
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.....	85.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.....	155.00
D7220	Removal of impacted tooth - soft tissue.....	175.00
D7230	Removal of impacted tooth - partially bony.....	220.00
D7240	Removal of impacted tooth - completely bony.....	240.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.....	280.00
D7250	Removal of residual tooth roots (cutting procedure).....	160.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.....	195.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.....	195.00
D7510	Incision and drainage of abscess - intraoral soft tissue.....	130.00
D7961	Buccal/labial frenectomy (frenulectomy).....	205.00
D7962	Lingual frenectomy (frenulectomy).....	205.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.....	175.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.....	30.00

**Plan Benefits are not available for any service that is both (a) received from a Non-Plan Specialty Dentist and (b) not listed on the Plan Benefit Schedule above.** Note: Plan Benefits are not available for Orthodontic services provided by a Non-Plan Specialty Dentist.

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## Assumptions

This dental plan does not provide coverage for pediatric oral health services that satisfies the requirements for "minimum essential coverage" as defined by the Patient Protection and Affordable Care Act. ("PPACA").



# Limitations & Exclusions

## Termination

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### Pre-existing Conditions

Limitations and exclusions apply with respect to the Member's oral conditions without regard to whether or not such conditions existed before the effective date of the Member's enrollment.

### Limitations and Exclusions

Plan Benefits are not available for:

1. Any services not specifically described in the Copayment Schedule (including but not limited to any hospital or outpatient care facility cost associated with any dental service). However, the reference to "hospital or outpatient care facility" does not include a dentist's office, dental clinic, or other comparable facility when the services described in the Copayment Schedule qualify as Emergency Services as defined in the Evidence of Coverage.
2. Any part of any dental service for which (a) a charge is incurred before the effective date of Member's enrollment for Plan Benefits (except as provided in the ORTHODONTIA SERVICES Section of the Copayment Schedule) or (b) after Member's enrollment for Plan Benefits ends. This exclusion means only that payment of the incurred charge, at the provider's entire normal retail cost for that part of that service, remains the Member's responsibility after the Member enrolls for Plan Benefits.
3. Services provided by Non-Plan Providers unless (a) for services of Non-Plan Specialty Dentists as specifically provided in the SPECIALTY DENTIST SERVICES section of the Copayment Schedule or (b) for medically necessary services and Emergency Services as specifically provided in the MEDICALLY NECESSARY AND EMERGENCY PROCEDURES Article of the Evidence of Coverage.
4. Replacement of bridgework, dentures or other fixed or removable appliances unless (a) at least five years have elapsed since such appliance was provided as a Plan Benefit, or (b) during that five-year period, appliance becomes unusable and cannot be made usable due to the Member's illness or an accident involving damage to the appliance while it is in use.
5. Replacement of dentures or other removable appliances due to (a) damage while not in use or (b) loss or theft.
6. Oral reconstruction using fixed bridgework or other fixed appliances if the overall treatment plan to achieve complete oral reconstruction involves the replacement of six or more teeth (whether those teeth are missing before treatment begins or are extracted as part of the overall treatment plan).
7. Implants or any related implant appliances, or surgery for the insertion of implants or any related implant appliances, whether fixed or removable.
8. Surgical removal of implants or implant appliances, or any surgical or non-surgical services to adjust, repair, replace, or treat any problem related to an existing implant or implant appliance, whether fixed or removable.
9. Restorations or splints used to increase vertical dimension, restore occlusion, or replace or stabilize tooth structure lost by attrition.
10. Orthodontic treatment involving therapy for myofunctional problems, TMJ (temporomandibular joint) dysfunctions, micrognathia, macroglossia, cleft palate or other growth and developmental abnormalities.
11. Orthodontic treatment associated with orthognathic surgery, whether the treatment precedes or follows the surgery.
12. Extractions of third molars (wisdom teeth) that are not symptomatic, whether or not the extractions follow the completion of orthodontic treatment. Examples of symptomatic conditions include decay, ontogenic cysts, chronic pericoronitis and infection.
13. Treatment of malignancies, neoplasms or cysts, including but not limited to biopsies.

### Orthodontic Extractions

Extractions by a Plan Provider for solely orthodontic purposes are not subject to the fixed Copayments shown for extractions in the Copayment Schedule. Instead, such extractions are subject to charges reflecting a 25% reduction from that Plan Provider's normal retail charges for such extractions.

**Orthodontic Treatment**

If Member was covered under Group's Prior Plan on the day before the Group's Prior Plan was replaced by this Plan, we will provide a pro-rated orthodontic benefit subject to the following conditions:

- A. Orthodontic treatment must already be in progress on the effective date of this Plan;
- B. Service must be listed under ORTHODONTIA SERVICES Section of the Copayment Schedule;
- C. Dentist providing orthodontic treatment under the Prior Plan must have been under contract with Company when providing treatment; and
- D. Member must be less than 24-months into orthodontic treatment.

The pro-rated benefit will be based on the amount of time remaining on Member's 24-month course of orthodontic treatment. The pro-rated benefit will be provided to Plan Provider, and Plan Provider will subtract the pro-rated benefit from Member's balance.

**Services of Non-Plan Specialty Dentists**

Except as otherwise provided in the Plan, Plan Benefit payments for services of Non-Plan Specialty Dentists, as provided in the NON-PLAN SPECIALTY DENTIST SERVICES Section of the Copayment Schedule, are limited to a total of \$2,000.00 per calendar year.

**Termination**

The Member's enrollment may be terminated as stated in the **TERMINATION** article of the Evidence of Coverage.