Subscription Certificate & Evidence of Coverage

Your Dental Plan & How To Use It

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GG-014276

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

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CERTIFICATE AMENDMENT

(To be attached to your Subscription Certificate)

Group: NORTHWEST SUBURBAN SPECIAL EDU

Amendment Effective: July 1, 2009

This rider amends your Subscription Certificate by revising the definition of "Dependent" to read as follows:

Dependent means your (a) spouse (unless legally separated); (b) unmarried dependent children who are under age 26; and (c) unmarried dependent children who are under age 30, if the children (i) are Illinois residents; (ii) served as members of the active or reserve components of any of the branches of the Armed Forces of the United States; and (iii) have received a release or discharge, other than a dishonorable discharge.

Eligible children include natural or adopted children, children placed for adoption, stepchildren, and foster children for whom you or your spouse are the legal guardian. Eligibility may also be extended to any child past the age of 26 who is handicapped and dependent on you for support.

Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

First Commonwealth Insurance Company

Richard A. Goren, DDS
President

Welcome to First Commonwealth

We at First Commonwealth are pleased that you have become a member of our dental plan. We encourage you to maintain your oral health by visiting your participating General Dentist on a regular basis.

To assist you in using your dental care coverage, we have made this booklet available to you. Please review it carefully and keep it with your other important documents. This booklet is issued in conjunction with a Group Master Policy which contains other details regarding your coverage. Your Group maintains a copy of the Group Master Policy. You may inspect it at any time at the Group's office during their normal business hours or, if you prefer you may contact First Commonwealth.

First Commonwealth
550 West Jackson Blvd., Suite 800
Chicago, IL 60661
Member Services: (866) 494-4542
www.firstcommonwealth.net

For Your Information

By acceptance of coverage under the terms of the Group Master Policy, Subscriber authorizes every provider rendering services hereunder to disclose all treatment facts pertaining to Subscriber and Dependents to us upon request.

Furthermore, you as the Subscriber represent to the best of your knowledge or information that information contained in any applications, forms or statements submitted to First Commonwealth shall be true, correct and complete and all rights to Plan Benefits are subject to the condition that all such information shall be true, correct and complete.

Please be aware that all rights of you and your enrolled Dependents to receive Plan Benefits are personal and may not be assigned to anyone else.

For Assistance Call (866) 494-4542

Our specially trained Member Services Representatives are available Monday through Friday, from 8:00 am to 7:00 pm (CST) to assist you. They can answer any questions you may have regarding how your dental plan works, assist in selecting or changing a General Dentist, assist in status changes and handle any inquiries or complaints you may have.

Your Effective Date of Coverage and Eligibility

Your Group determines the effective date of your coverage and who is eligible to participate. This is specified in the Group Application.

As the Subscriber, you may enroll yourself alone, or together with your spouse and/or eligible dependent children (subject to age limits under your Group's program). If you do not enroll your Dependent(s) on the date you enroll, you must wait to add them until the next Open Enrollment.

Dependents may be added, deleted, or you may change your coverage status on the date of the qualifying event, provided that First Commonwealth is notified in writing at least thirty one (31) days after the date of the qualifying event.

Children that are newly acquired Dependents through adoption or children placed for adoption may be enrolled on the date of the qualifying event, if First Commonwealth is given written notice within sixty (60) days of the qualifying event.

Qualifying Events

1. Marriage
2. Birth
3. Adoption
4. Children Placed for Adoption
5. Becoming a legal guardian of a child
6. Divorce
7. Death

Enrollment/Eligibility Period

Your enrollment in this Plan is for a minimum of twelve (12) consecutive months while eligible through your Group. Enrollment into this Plan or voluntary termination from this Plan will only be allowed during Open Enrollment periods which are determined by your Group and First Commonwealth. Persons not enrolled when first eligible may be enrolled only during your Group's next Open Enrollment period.

Choice of Participating Dental HMO Offices

You and your Dependents must select a participating General Dentist from the directory of General Dentists. Each member of your family may select a different dental location from the directory. Each dental office is privately owned and establishes their own policies, procedures and hours.

In order to obtain Plan Benefits, you must select a Participating Dental HMO Dentist and receive care from that dentist**. Care rendered by a non-participating dentist, or care rendered by a Specialist without obtaining prior written authorization for such care, is not a Plan Benefit.**

Dental HMO Quality Assessment

Participating General Dentists and Specialists must meet certain standards prior to acceptance in our network. Availability, access to care, license standing, professional liability insurance coverage, emergency care provisions, National Practitioner Data Bank ("NPDB") reports and State Board ("BODEX") histories are some of the factors considered in reviewing an application.

First Commonwealth periodically reviews the care provided through a peer review process. If you have any questions or concerns about the care you are receiving, you are encouraged to review them first with your Participating General Dentist or Specialist. Our Member Services Department is also available to answer any questions you may have or to discuss any concern you may have.

Changing Your Dental Office Selection

You may change your participating dental office at any time during the benefit year. A change can be made by calling our Member Services Department (866) 494-4542 with the change information. If First Commonwealth is notified by the 15th of the month the change will be effective the first of the following month. If you notify First Commonwealth after the 15th of the month, the change will be effective the first day of the second month following your request. You may call your new dental office to schedule an appointment after your request for a change has become effective.

Specialty Care Referrals

Certain Plan Benefits require the services of a specialist (i.e. some oral surgery, orthodontics, endodontics, periodontics and pedodontics). In those cases, your dental HMO general dentist will refer you to a participating specialist. **You will be provided with a copy of the referral form to present to the specialist at the time of your appointment.**

How To Make An Appointment

You may schedule appointments with your General Dentist by calling the selected office **after your effective date of coverage.** When you call to schedule your appointment, notify the office that you are a member of First Commonwealth's dental plan. Be aware that you, like all other patients at your dentist's office, may need to wait longer for appointments at peak times (e.g. evenings, weekends). If you are flexible on time and days, you should generally expect to receive a routine appointment within several weeks of calling.

Appointments You Cancel

The time set aside for you is very valuable to your dentist. **Therefore, if you cannot keep an appointment, notify the dental office at least 24 hours in advance.** A charge may be assessed for broken appointments with less than 24 hours notice. Frequent broken appointments can result in your inability to establish and maintain a satisfactory dentist-patient relationship and thereby jeopardize our ability to provide you with ongoing coverage.

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Emergency Care

Emergency Care means the provision of dental care for the sudden and, at the time, unexpected onset of a dental condition which would lead a prudent layperson to believe that failure to receive immediate dental care would result in a serious problem to the teeth or would place the person's oral health in serious jeopardy.

In Area Emergency Care: If you are in the plan service area and need Emergency Care, you should call your General Dentist. All General Dentists are required to have arrangements for 24-hour Emergency Care. If your General Dentist is unable to make arrangements for Emergency Care, you should call our Member Services Department. If you are unable to reach First Commonwealth(e.g. you are calling during non-business hours), you should seek care from any licensed dentist to alleviate the emergency condition only.

Out of Area Emergency Care: If you are more than fifty miles from your General Dentist and need Emergency Care, you should seek care from any licensed dentist to alleviate the emergency condition only.

If you receive Emergency Care out of network: You must call First Commonwealth's Member Services Department within seventy-two (72) hours after Emergency Care is provided to you by a non- participating dentist. The Member Services Representative will direct you to submit the dentist's bill listing the Emergency Care services to First Commonwealth within thirty days. Upon review, you will be reimbursed within thirty days of First Commonwealth's receipt of all information relevant to your Emergency Care less any applicable Copayment. Your reimbursement will be in accordance with plan benefits needed for the relief of acute pain, swelling or trauma.

Follow-up Care: Follow-up care, if needed, should be rendered by your General Dentist.

Identification Cards

You will receive an identification card (one per household per provider selected). It identifies you as the Subscriber eligible for services and lists the number of family Dependents registered at the selected dental office. The identification card also contains the phone number for you to call to schedule an appointment or Emergency Care with your dentist.

The identification card serves as a reminder of the Plan Benefits under which you are enrolled and the Participating Dental HMO Office you have selected. **You do not need the card to schedule an appointment nor do you need more than one card per family.** The card is only issued for your convenience, and is not a guarantee of coverage.

The identification card contains the First Commonwealth Member Services Department phone number and the address to send any Emergency Care claim forms or other correspondence to First Commonwealth.

Your Payment Responsibilities (Copayment)

Copayments represent your portion of the total cost of Plan Benefits paid to the participating dental offices. You and your Dependents are responsible for paying the Copayment for the covered benefit at the time of service.

The coverage levels contained in the Schedule of Benefits section of this booklet are guaranteed under this contract. All coinsurance percentages are applied to an annual fee schedule that Participating Dental HMO offices have agreed to accept. Your portion of the cost, i.e., your Copayment is based on this fee schedule and will not vary, based on which Participating Dental HMO Office you choose or your dentist's customary charges for services rendered.

Compensation of Participating Dentist

A participating dentist receives a fixed payment for eligible members enrolled in the dentist's practice. Payment is made irrespective of the number of services rendered or eligible members seen. The total compensation that a participating dentist receives is equal to this fixed payment plus reimbursement for services actually rendered based on the annual fee schedule that participating dentists have agreed to accept.

Coordination of Benefits

The benefits of this dental plan may be coordinated with another dental plan according to the terms of your Group Master Policy.

Automatic Renewal of Coverage

Your coverage will automatically be renewed each year unless you notify your Group of your intent to terminate coverage no later than thirty-one days prior to the renewal date.

Refusing Treatment

A Member may decide to refuse a course of treatment recommended by their General Dentist or Specialist. Members can request and receive a second provider's opinion by contacting Member Services. If the recommended treatment is still refused, the General Dentist or Specialist will have no further responsibility to provide services for the condition involved and the Member may be required to select another General Dentist or Specialist.

Termination of Coverage

Plan Benefits may be terminated immediately for any of the following reasons:

1. Termination of the Group Master Policy.
2. Your (or your eligible enrolled Dependents) failure to meet the eligibility requirements.
3. A Member's failure to pay applicable Copayments when due.
4. Material misrepresentation (fraud) in obtaining coverage.
5. Permitting the use of your identification card by another person, or using another person's identification card to obtain care to which one is not entitled.
6. Failure to establish a satisfactory dentist/patient relationship with a First Commonwealth Dental HMO Dentist.
7. Failure of Group or individual member (if applicable) to pay a Premium in a timely manner.

Coverage for a Subscriber and his/her Dependents will terminate according to the terms of the Group Master Policy, except for any of the reasons (1- 7) above when termination is immediate. In the event coverage is terminated, the Member shall become liable for charges resulting from treatment received after termination.

Complaint Resolution Procedures

We, our staff, and affiliated dental HMO dentists are committed to providing quality dental services in a convenient and accessible fashion. It is our commitment to do that in a manner which continually meets our Members' expectations. The Complaint Resolution Procedure is as follows:

If you have questions, concerns, comments or complaints about services, personnel or facilities that cannot be resolved to your satisfaction after speaking directly with the dentist or other concerned party, please contact us in writing or by phone. Our internal service standards require, where possible, to resolve all Member's inquiries and concerns immediately. If however resolving the issue will require additional time, the Member will be given the best estimate of the amount of time needed for resolution.

If your complaint has not been resolved to your satisfaction, you have the right to appeal our decision. You may do so by submitting, in writing, the reasons why you disagree with our decision along with any additional information you wish us to consider. This appeal should be submitted no later than 30 days from the date of our original decision or from the date of the incident. You will receive an acknowledgement of our receipt of the appeal advising you of when to expect a written response.

The appeal will then be sent to the President for a final review and decision. The President, at his sole discretion, may advise you of a hearing date to review the complaint and consider all the facts. You must attend the hearing (up to three dates will be considered). If following the outcome of the appeal process you are still dissatisfied with the resolution, you may choose to notify the State of Illinois Department of Insurance at:

Consumer Service Department
Illinois Department of Insurance
320 West Washington
Springfield, IL 62767
or
Illinois Department of Insurance
100 West Randolph, Suite 15-100
Chicago, IL 60601-3251

Definitions

Copayment means your portion of the cost of services rendered that you pay the dentist directly at the time services are performed. Your copayment is based on a fee schedule that all participating dentists have agreed to accept and the applicable coinsurance rate determined from the Schedule of Benefits. Copayments are adjusted on January 1st each year based on adjustments in the fee schedule accepted by participating providers. All providers charge the same copayments (for the same services) based on the fee schedule in effect at the time services are rendered.

Dependent means your spouse (unless legally separated) and/or unmarried children up to the age of 26. Eligible children include natural or adopted children, children placed for adoption, stepchildren, and foster children for whom you or your spouse are the legal guardian. Eligibility may be extended up to the age of 30 to any of your children who are registered students in full-time attendance at an accredited school, college, or university. Eligibility will also be extended to any child past the age of 26 who is handicapped and dependent on you for support.

Emergency Care means the provision of dental care for the sudden and, at the time, unexpected onset of a dental condition which would lead a prudent layperson to believe that failure to receive immediate dental care would result in a serious problem to the teeth or would place the person's oral health in serious jeopardy.

Exclusion means any service which is not a Plan Benefit.

First Commonwealth means First Commonwealth Insurance Corporation, an Illinois domiciled Life, Accident and Health Insurance Company that is also licensed as a limited health services organization. First Commonwealth has entered into a Group Master Policy with your Group to provide eligible subscribers and dependents with the Plan Benefits described in this booklet.

General Dentist means a Participating Dental HMO general dentist that the Member selects from the dental HMO participating dentist list to provide or arrange for all dental care needs.

Group means your employer, labor union, trust, association, partnership, or other organization to which we issue a Group Master Policy, and through which you have become entitled to the Plan Benefits described in this brochure.

Group Master Policy means the contract issued to the Group that contains all the provisions of coverage.

Limitation means any restriction on a Plan Benefit.

Member means you or a covered dependent who is actually enrolled in the plan.

Participating Dental HMO Dentist means a general or specialty dentist who is under contract to First Commonwealth of Illinois, Inc., a Preferred Provider Administrator registered with the Illinois Department of Insurance. First Commonwealth of Illinois, Inc., through its contracts with dentists, arranges for all covered dental services pursuant to its contract with First Commonwealth and on file with the Illinois Department of Insurance. Participating dental HMO providers shall include any hygienists and technicians recognized under Illinois law to act with and assist the dentist.

Plan Benefit means those specific dental benefits and charges covered by us and described in this booklet.

Premium means the amount you the Subscriber, or by the Group (on your behalf), pays to us to maintain coverage according to the terms of the Group Master Policy. You agree to have any required contribution towards premium be collected by the Group and remitted to us.

Service Area means the geographic area in which we provide our dental HMO Plan Benefits.

Specialist means a Participating Dental HMO dentist who has satisfied the additional training requirements in a specific area of dentistry and obtained a separate license to practice in that specialty area. Examples of dental specialists include Oral Surgeons, Endodontists (root canals), Periodontists (gum surgery), Orthodontists (braces) and Pedodontists (special needs of children).

Subscriber means you, the eligible person from the Group that enrolls in the benefit plan.

SCHEDULE OF BENEFITS - PLAN 7000

The coverage shown below is applied to the First Commonwealth fee schedule that is in effect in your area from January 1st to December 31st each year. For services covered at 100%, you pay nothing except any applicable office visit copayment. For services covered at less than 100%, your Payment Responsibility is based on the First Commonwealth fee schedule in effect at that time and any applicable office visit copayment. A current schedule listing your Payment Responsibility for each covered service is available through your Group or by calling Member Services.

Office Visit Copayment: There is a $0 office visit copayment due each time you visit your participating Dental HMO Dentist.

Type of Service	Plan Covers

PREVENTIVE & DIAGNOSTIC SERVICES

Oral Examinations 100%

Initial, Periodic, Emergency & Limited Exams, Detailed & Extensive Oral Evaluation

X-Rays 100%

Intraoral, Periapical, Occlusal, Bitewing & Panoramic

Other Diagnostic Services 100%

Diagnostic Casts, Caries Indicators, Pulp Vitality Tests

Routine Preventive Services 100%

Prophylaxis (cleaning), Fluoride Application, Nutritional Counseling, Oral Hygiene Instruction, Sealants

MINOR SERVICES

Minor Restorative 85%

Amalgams, Anterior Direct Composite Resins, Sedative Fillings, Recementation of Crown & Inlays

Endodontics 85%

Root Canal Therapy, Pulp Capping, Retrograde Filling, Pulpotomies, Apicoectomies, Apexification, Root Amputation, Hemisection, Canal Preparation for Posts, Pulpal Therapy

Periodontics 85%

Gingival & Osseous Surgery, Gingival Flap Procedure, Gingivectomy, Bone & Tissue Grafts, Distal or Proximal Wedge, Crown Lengthening, Periodontal Maintenance Procedures, Periodontal Scaling & Root Planing, Gingival Curettage, Full Mouth Debridement

Oral Surgery 85%

Surgical Extractions of Impacted Teeth, Alveoplasties, Frenectomies, Surgical Exposure to Aid Eruption, Removal of Residual Roots, Removal of Benign Odontogenic Cyst or Tumor

MAJOR SERVICES

Removable Dentures 80%

Complete, Immediate & Partial Dentures, Denture Adjustments Including Reline, Rebase & Repairs, Tissue Conditioning

Crown & Fixed Bridges 80%

Inlays & Onlays (indirect laboratory fabricated metallic, resin & ceramic) & Crowns (indirect laboratory fabricated metallic, metallic/ceramic, metallic/resin), Pin Retention, Post & Core, Core Build-Ups, Repairs of Crown & Bridgework, Pre-Fabricated Crowns

OTHER SERVICES

Local Anesthesia 100%

Miscellaneous 85%

Space Maintainers, Occlusal Adjustments, Consultation, Desensitizing Medicaments, Treatment for Temporary Relief of Pain (emergency)

Cosmetic 50%

Labial Veneers

General Anesthesia 50%

For Oral Surgery When Medically Necessary

ORTHODONTICS

Class I or II Malocclusion . . . . $1,000 savings*

* Your Payment Responsibility for Orthodontic Services is based on the First Commonwealth fee schedule in effect at the time treatment is initiated. Your Payment Responsibility represents a $1,000 savings off the prevailing orthodontic fees in the community.

Procedures, services, or treatment not specifically listed in this Schedule of Benefits are excluded. Any non-covered service may be rendered by a General Dentist or Specialist for the usual fee upon agreement by the dentist and Member. Payment for non-covered services will be the sole responsibility of the Member.

Limitations

All time Limitations are determined from the date that service was last rendered.

1. Bitewing radiographs are covered every six (6) months, not to exceed twice in any calendar year. Full mouth radiographs (periapical series with bitewings or panoramic) are covered once every thirty-six (36) months.
2. Routine oral evaluations, prophylaxis, and fluoride treatments are covered once every six (6) months, not to exceed twice in any calendar year.
3. Sealants may only be applied to permanent posterior teeth for children through age 16 and are limited to one treatment every eighteen (18) months.
4. Periodontal scaling and root planing is covered once every twelve (12) months.
5. Periodontal maintenance procedures are covered once every six (6) months, not to exceed twice in any calendar year.
6. Denture relines will be limited to one (1) under this Plan every three (3) years.
7. Crowns, fixed bridgework, and/or removable prosthetic appliances, other than stainless steel crowns, are covered after five (5) years have elapsed from any prior placement, unless the prosthetic appliance becomes unsatisfactory due to illness, significant changes in the oral condition, or other causes not controlled by ordinary circumstances.
8. Crowns and inlays (cast restorations) are covered only if there is insufficient tooth structure to retain a direct filling.
9. When the Member is missing more than four (4) functionally unrestored teeth in an arch (excluding third molars), the replacement of these missing teeth with fixed bridgework is not covered.
10. This Plan provides for crowns, fixed bridgework, and removable prosthetic appliances using standard materials and procedures. The Member will be responsible for any additional charges resulting from any optional materials and/or procedures, including but not limited to:
    a. High noble metal (gold) used in fixed or removable restorations/prosthetic appliances
    b. Precision attachments/partials
    c. Over dentures
    d. Implants (placement or removal)
    e. Personalization, customization, or characterization of any fixed or removable prosthetic appliance.
11. Use of nitrous oxide analgesia is at the discretion of the dentist and may not be available at all locations.
12. General anesthesia is limited to professional fees only, in instances where the health of the patient would be compromised if not administered and the patient requires a covered oral surgical service. Documentation from a medical physician must be provided in advance and all cases must be pre-approved by First Commonwealth. Patient comfort, convenience, or anxiety alone are not conditions for which general anesthesia will be covered.
13. Referrals for pedodontic specialty care are limited to:
    a. Children through age five (5) for behavioral management issues, or
    b. Children through age twelve (12) with severe or unusual dental problems or who are otherwise disabled, who, in the opinion of the First Commonwealth Dental Director, require the expertise of a specialist.

Exclusions

Your First Commonwealth plan does not provide coverage for the following:

1. Services rendered by other than the Member's Participating General Dentist and/or Specialist.
2. Dental services not listed on the Schedule of Benefits.
3. Charges for the use of any facility, equipment, and/or supplies provided outside the Participating Dental HMO Office.
4. Treatment in progress at the inception of this Plan, or dental treatment and expenses incurred prior to the Member's eligibility to receive Plan Benefits under this Plan, or after the termination of the Member's coverage.
5. Dental services rendered specifically for cosmetic purposes, except as may be indicated on the Schedule of Benefits.
6. Procedures, appliances, or restorations (including orthodontic treatment) to correct congenital or developmental malformations, including anodontia.
7. Plan Benefits are limited to procedures necessary to eliminate oral disease and replace missing natural teeth. Procedures, appliances, or restorations (other than fillings) that are necessary as part of full mouth reconstruction are not covered, including, but not limited to:
    a. Increasing vertical dimension
    b. Periodontal splinting
    c. Gnathologic recordings
    d. Equilibration
    e. Treatment of TMJ disturbances or disorders
    f. Realignment of teeth
    g. Replacing or stabilizing tooth structure loss due to attrition
    h. Orthodontic treatment
8. Experimental dental, surgical, or health care procedures.
9. Dental services which, in the opinion of the Participating General Dentist or Specialist, will not achieve a satisfactory result, cannot be performed because of the general health or physical limitations of the Member, or which are not normally indicated for the treatment of dental disease.
10. Duplication of any appliance or replacement of fixed or removable prosthetic restorations or appliances due to loss, theft, or damage.
11. Failure of prosthodontic, orthodontic, or any other appliances or services due to abuse and/or neglect by the Member.
12. Dental implant procedures and related dental services, including crowns and/or fixed bridgework supported by implants.
13. Interim crowns, bridges or dentures not incidental to an ongoing course of treatment.
14. Services which are covered under other non-dental insurance plans, which are covered through Worker's Compensation or Employer Liability Laws or for which coverage exists through any municipality, county, military or other political entity or which are covered by any medical policy. This Plan does not duplicate coverage for Dental services.
15. Treatment for or removal of malignancies, neoplasms, cysts, or genetic malformations, except as specifically listed on the Schedule of Benefits.
16. Diagnosis and services and/or procedures related to the treatment of temporomandibular joint (TMJ)-related disturbances/disorders.
17. Preventive control programs, including but not limited to, soft tissue management program.
18. Expenses relating to dental health record duplication and transfers.

19. The following Orthodontic services are excluded:
    a. Lingual or clear bands/brackets
    b. Interceptive orthodontic appliances and treatment
    c. Replacement of appliances due to theft, loss, or breakage
    d. Retreatment of orthodontic cases
    e. Treatment in progress at inception of eligibility
    f. Changes in treatment necessitated by an accident
    g. Orthodontic treatment that involves:
        i. maxillofacial surgery
        ii. myofunctional therapy
        iii. cleft palate
        iv. micrognathia
        v. macroglossia
        vi. hormonal imbalances causing growth and development abnormalities
        vii. treatment related to temporo-mandibular joint disturbances/ disorders

Orthodontic treatment is limited to one full course of twenty-four (24) continuous months of active treatment under this Plan using conventional metal bands/brackets.

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YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com

DENTAL HMO PLAN 7000 SCHEDULE OF MEMBERS' PAYMENT RESPONSIBILITY

Effective 1-1-13 to 12-31-13

DIAGNOSTIC

Code	Procedure	Copay
D0999	Office Visit Copay	$5
D0120	Periodic Oral Evaluation	$0
D0140	Limited Oral Evaluation - Problem Focused	$0
D0145	Oral Eval for Patient under 3 & Counseling with Primary Caregiver	$0
D0150	Comprehensive Oral Evaluation - New or Established Patient	$0
D0160	Detailed & Extensive Evaluation, Problem Focused	$0
D0170	Re-Eval - Limited, Problem Focused (Est. Patient, Not Post-Operative)	$0
D0180	Comprehensive Periodontal Examination, New or Established Patient	$0
D0210	Intraoral - Complete Series (Including Bitewings)	$0
D0220	Intraoral - Periapical First Film	$0
D0230	Intraoral - Periapical Each Additional Film	$0
D0240	Intraoral - Occlusal Film	$0
D0270	Bitewing - Single Film	$0
D0272	Bitewing X-Rays - 2 Films	$0
D0273	Bitewing X-Rays - 3 Films	$0
D0274	Bitewing X-Rays - 4 Films	$0
D0277	Vertical Bitewings - 7 to 8 Films	$0
D0330	Panoramic Film	$0
D0415	Bacteriological Studies	$0
D0460	Pulp Vitality Tests	$0
D0470	Diagnostic Casts	$0

PREVENTIVE

Code	Procedure	Copay
D1110	Prophylaxis - Adult	$0
D1120	Prophylaxis - Child	$0
D1206	Topical Fluoride Varnish, Therapeutic Application for Mod to High Caries Risk Patients	$12
D1208	Topical Application Of Fluoride	$0
D1310	Nutritional Counseling for Control of Dental Disease	$0
D1330	Oral Hygiene Instructions	$0
D1351	Sealant - Per Tooth	$0
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient-Permanent Tooth	$0
D1510	Space Maintainer - Fixed - Unilateral	$53
D1515	Space Maintainer - Fixed - Bilateral	$70
D1520	Space Maint-Removable - Unilateral	$61
D1525	Space Maint-Removable - Bilateral	$84
D1550	Re-Cementation of Space Maintainer	$11
D1555	Removal of a Space Maintainer, By Dentist Who Did Not Originally Place	$18

MINOR RESTORATIVE

Code	Procedure	Copay
D2140	Amalgam - 1 Surface, Primary or Permanent	$19
D2150	Amalgam - 2 Surfaces, Primary or Permanent	$24
D2160	Amalgam - 3 Surfaces, Primary or Permanent	$28
D2161	Amalgam - 4 or More Surfaces, Primary or Permanent	$36
D2330	Resin-Based Composite - 1 Surface, Anterior	$23
D2331	Resin-Based Composite - 2 Surfaces, Anterior	$27
D2332	Resin-Based Composite - 3 Surfaces, Anterior	$37
D2335	Resin-Based Comp - 4 or More Surfaces or Involving Incisal Angle (Anterior)	$41
D2390	Resin-Based Composite Crown, Anterior	$44
D2391	Resin-Based Composite - 1 Surface, Posterior	$27
D2392	Resin-Based Composite - 2 Surfaces, Posterior	$36
D2393	Resin-Based Composite - 3 Surfaces, Posterior	$42
D2394	Resin-Based Composite - 4 or More Surfaces, Posterior	$51
D2929	Prefabricated Porcelain/Ceramic Crown – Primary Tooth	$65
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	$0

ENDODONTICS

Code	Procedure	Copay
D3110	Pulp Cap - Direct (Excluding Final Restoration)	$9
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	$8
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	$29
D3221	Pulpal Debridement, Primary & Permanent Teeth	$29
D3222	Partial Pulpotomy for Apexogenesis – Perm. Tooth with Incomplete Root	$29
D3230	Pulp Therapy, Anterior Primary	$32
D3240	Pulp Therapy, Posterior Primary	$34
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	$113
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	$133
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	$172
D3346	Retreatment of Previous Root Canal Therapy - Anterior	$161
D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	$251
D3348	Retreatment of Previous Root Canal Therapy - Molar	$300
D3351	Apexification/Recalcification First Visit	$68
D3352	Apexification/Recalcification Interim Visit	$32
D3353	Apexification/Recalcification Final Visit	$83
D3410	Apicoectomy/Periradicular Surgery - Anterior	$122
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	$127
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	$139
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	$56
D3430	Retrograde Filling - Per Root	$41
D3450	Root Amputation Per Root	$72
D3920	Hemisection (Incl. Root Removal/Excludes Rct)	$55
D3950	Canal Prep & Fit of Preformed Post (By Other Than Dentist Who Placed Post)	$21

PERIODONTICS

Code	Procedure	Copay
D4210	Gingivectomy or Gingivoplasty - 4 or More Teeth Per Quadrant	$94
D4211	Gingivectomy or Gingivoplasty - 1 to 3 Teeth, Per Quadrant	$27
D4212	Gingivectomy or Gingivoplasty to Allow Access For Restorative Procedure, Per Tooth	$19
D4240	Gingival Flap Procedure, W/Root Planing - 4 or More Teeth Per Quadrant	$108
D4241	Gingival Flap Procedure, W/Root Planing - 1 to 3 Teeth, Per Quadrant	$71
D4245	Apically Positioned Flap	$116
D4249	Clinical Crown Lengthening - Hard Tissue	$132
D4260	Osseous Surgery (Incl. Flap Entry & Closure) - 4 or More Teeth Per Quad	$177
D4261	Osseous Surgery (Incl. Flap Entry & Closure) - 1 to 3 Teeth, Per Quad	$122
D4263	Bone Replacement Graft, First Site in Quadrant	$100
D4264	Bone Replacement Graft, Each Additional Site in Quadrant	$73
D4268	Surgical Revision Procedure, Per Tooth, Inclusive in Surgery	$0
D4270	Pedicle Soft Tissue Graft Procedure	$132
D4273	Subepithelial Connective Tissue Graft	$152
D4274	Distal or Proximal Wedge	$49
D4275	Soft Tissue Allograft	$145
D4276	Combined Connective Tissue & Pedicle Graft	$155
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery), First Tooth or Edentulous Tooth Position In a Graft	$152
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) Each Additional Contiguous Tooth or Edentulous Tooth Position in Same Graft Site	$91
D4341	Scaling & Root Planing - 4 or More Teeth Per Quadrant	$38
D4342	Scaling & Root Planing - 1 to 3 Teeth, Per Quadrant	$23
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation & Diagnosis	$24
D4381	Loc. Deliv. Chemo Agent, Controlled Release into Crevice, Per Tooth	$51
D4910	Periodontal Maintenance	$23

ORAL SURGERY

Code	Procedure	Copay
D7111	Extraction, Coronal Remnants - Deciduous Tooth	$14
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$21
D7210	Surg Removal of Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth; Inc. Mucoperiosteal Flap if Indicated	$41
D7220	Removal of Impacted Tooth - Soft Tissue	$56
D7230	Removal of Impacted Tooth - Partially Bony	$72
D7240	Removal of Impacted Tooth - Completely Bony	$86
D7241	Removal of Impacted Tooth - Completely Bony, with Unusual Surg Comp	$100
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	$52
D7280	Surgical Access of an Unerupted Tooth (Non-Orthodontic)	$73
D7310	Alveoloplasty w/Extractions - Per Quadrant	$46
D7311	Alveoloplasty w/Ext - 1 To 3 Teeth or Spaces, Per Quadrant	$22
D7320	Alveoloplasty Not w/Extractions - Per Quadrant	$80
D7321	Alveoloplasty Not W/Extractions - 1 to 3 Teeth or Spaces Per Quadrant	$55
D7450	Removal of Benign Odontogenic Cyst or Tumor (Diameter <= 1.25 Cm)	$140
D7451	Removal of Benign Odontogenic Cyst or Tumor (Diameter >1.25 Cm)	$199
D7510	Incision & Drainage of Abscess - Intraoral Soft Tissue	$40
D7511	Incision & Drainage of Abscess - Intraoral Soft Tissue - Complicated	$43
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	$82
D7963	Frenuloplasty	$142
D7972	Surgical Reduction of Fibrous Tuberosity	$85

CROWNS

Code	Procedure	Copay
D2510	Inlay - Metallic - 1 Surface*	$156
D2520	Inlay - Metallic - 2 Surfaces*	$176
D2530	Inlay - Metallic - 3 or More Surfaces*	$183
D2542	Onlay - Metallic - 2 Surfaces*	$183
D2543	Onlay - Metallic - 3 Surfaces*	$191
D2544	Onlay - Metallic - 4 or More Surfaces*	$203
D2610	Inlay - Porcelain Ceramic 1 Surf	$156
D2620	Inlay - Porcelain Ceramic 2 Surf	$176
D2630	Inlay - Porcelain Ceramic 3 Surf	$183
D2642	Onlay - Porcelain Ceramic 2 Surf	$188
D2643	Onlay - Porcelain Ceramic 3 Surf	$191
D2644	Onlay - Porcelain Ceramic 4+ Surf	$203
D2650	Inlay - Resin 1 Surf	$141
D2651	Inlay - Resin 2 Surf	$163
D2652	Inlay - Resin 3 Surf	$168
D2662	Onlay - Resin 2 Surf	$173
D2663	Onlay - Resin 3 Surf	$181
D2664	Onlay - Resin 4+ Surf	$188
D2710	Crown - Resin-Lab	$91
D2720	Crown - Resin, High Noble Metal*	$202

DENTAL HMO PLAN 7000 continued

CROWNS (cont.)

Code	Procedure	Fee
D2721	Crown - Resin, Base Metal	$202
D2722	Crown - Resin, Noble Metal	$210
D2740	Crown - Porcelain/Ceramic Substrate	$220
D2750	Crown - Porcelain Fused to High Noble Metal*	$206
D2751	Crown - Porcelain Fused to Predominantly Base Metal	$206
D2752	Crown - Porcelain Fused to Noble Metal	$210
D2780	Crown - 3/4 Cast High Noble Metal*	$206
D2781	Crown - 3/4 Cast Predominantly Base Metal	$202
D2782	Crown - 3/4 Cast Noble Metal	$206
D2783	Crown - 3/4 Porcelain/Ceramic	$210
D2790	Crown - Full Cast High Noble Metal*	$206
D2791	Crown - Full Cast Predominantly Base Metal	$206
D2792	Crown - Full Cast Noble Metal	$210
D2794	Crown - Titanium	$206
D2910	Recement Inlay	$14
D2915	Recement Cast or Prefabricated Post & Core	$14
D2920	Recement Crown	$14
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$53
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	$60
D2932	Prefabricated Resin Crown	$65
D2933	Prefabricated Stainless Steel Crown with Resin Window	$72
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	$72
D2940	Protective Restoration	$14
D2950	Core Buildup, Including any Pins	$54
D2951	Pin Retention - Per Tooth, in Addition to Restoration	$12
D2952	Cast Post & Core in Addition to Crown*	$76
D2953	Each Additional Cast Post - Same Tooth*	$24
D2954	Prefabricated Post & Core in Addition to Crown	$62
D2957	Each Additional Prefabricated Post - Same Tooth	$14
D2970	Temp Crown, Factured Tooth - Immediate (not as temp during crown fabrication)	$48
D2971	Additional Procedures to Construct New Crown Under Existing Partial	$53
D2980	Crown Repair	$24

FIXED BRIDGES

Code	Procedure	Fee
D6205	Pontic - Indirect Resin Based Composite	$90
D6210	Pontic - Cast High Noble Metal*	$191
D6211	Pontic - Cast Predominantly Base Metal	$191
D6212	Pontic - Cast Noble Metal	$196
D6214	Pontic - Titanium	$191
D6240	Pontic - Porcelain Fused to High Noble Metal*	$191
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	$191
D6242	Pontic - Porcelain Fused to Noble Metal	$196
D6245	Pontic - Porcelain/Ceramic	$196
D6250	Pontic - Resin, High Noble Metal*	$191
D6251	Pontic - Resin, Base Metal	$191
D6252	Pontic - Resin, Noble Metal	$196
D6545	Retainer - Cast Metal for Resin Bonded Fixed Prosthesis*	$83
D6548	Retainer - Porcelain for Resin Bonded Prosthesis	$95
D6600	Inlay - Porcelain Ceramic-2 Surfaces	$171
D6601	Inlay - Porcelain Ceramic, 3 or More Surfaces	$183
D6602	Inlay - Cast High Noble Metal, 2 Surfaces*	$171
D6603	Inlay - Cast High Noble Metal, 3 or More Surfaces*	$183
D6604	Inlay - Cast Predominantly Base Metal, 2 Surfaces	$171
D6605	Inlay - Cast Predominantly Base Metal, 3 or More Surfaces	$183
D6606	Inlay - Cast Noble Metal, 2 Surfaces	$171
D6607	Inlay - Cast Noble Metal, 3 or More Surfaces	$183
D6608	Onlay - Porcelain Ceramic, 2 Surfaces	$188
D6609	Onlay - Porcelain Ceramic, 3 or More Surfaces	$203
D6610	Onlay - Cast High Noble Metal, 2 Surfaces*	$188
D6611	Onlay - Cast High Noble Metal, 3 or More Surfaces*	$203
D6612	Onlay - Cast Predominantly Base Metal, 2 Surfaces	$188
D6613	Onlay - Cast Predominantly Base Metal, 3 or More Surfaces	$203
D6614	Onlay - Cast Noble Metal, 2 Surfaces	$188
D6615	Onlay - Cast Noble Metal, 3 or More Surfaces	$203
D6624	Inlay - Titanium	$183
D6634	Onlay - Titanium	$203
D6710	Crown - Indirect Resin Based Composite	$91
D6720	Crown - Resin, High Noble Metal*	$206
D6721	Crown - Resin, Base Metal	$206
D6722	Crown - Resin, Noble Metal	$210
D6740	Crown - Porcelain/Ceramic	$220
D6750	Crown - Porcelain Fused to High Noble Metal*	$206
D6751	Crown - Porcelain Fused to Predominantly Base Metal	$206
D6752	Crown - Porcelain Fused to Noble Metal	$210
D6780	Crown - 3/4 Cast High Noble Metal*	$206
D6781	Crown - 3/4 Cast Predominantly Base Metal	$206
D6782	Crown - 3/4 Cast Noble Metal	$210
D6783	Crown - 3/4 Porcelain/Ceramic	$210
D6790	Crown - Full Cast High Noble Metal*	$206
D6791	Crown - Full Cast Predominantly Base Metal	$206
D6792	Crown - Full Cast Noble Metal	$210
D6794	Crown - Titanium	$206
D6930	Recement Fixed Partial Denture	$24
D6980	Fixed Partial Denture Repair, by report	$29

LABIAL VENEERS

Code	Procedure	Fee
D2960	Labial Veneer (Resin Laminate) - Chairside	$387
D2961	Labial Veneer (Resin Laminate) - Lab	$504
D2962	Labial Veneer (Porcelain Laminate) - Lab	$550

DENTURES

Code	Procedure	Fee
D5110	Complete Denture - Maxillary	$277
D5120	Complete Denture - Mandibular	$277
D5130	Immediate Denture - Maxillary	$296
D5140	Immediate Denture - Mandibular	$296
D5211	Maxillary Partial - Resin Base	$277
D5212	Mandibular Partial - Resin Base	$277
D5213	Maxillary Partial - Cast Metal Framework W/Resin Bases	$296
D5214	Mandibular Partial - Cast Metal Framework W/Resin Bases	$296
D5225	Maxillary Partial - Flexible Base	$305
D5226	Mandiublar Partial - Flexible Base	$305
D5281	Removable Unilateral Partial Denture	$168
D5410	Adjust Complete Denture - Maxillary	$13
D5411	Adjust Complete Denture - Mandibular	$13
D5421	Adjust Partial Denture - Maxillary	$13
D5422	Adjust Partial Denture - Mandibular	$13
D5510	Repair Broken Complete Denture Base	$33
D5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	$31
D5610	Repair Resin Denture Base	$38
D5620	Repair Cast Framework	$38
D5630	Repair or Replace Broken Clasp	$46
D5640	Replace Broken Teeth - Per Tooth	$30
D5650	Add Tooth to Existing Partial Denture	$39
D5660	Add Clasp to Existing Partial Denture	$49
D5670	Replace All Teeth & Acrylic on Cast Metal Framework - Maxillary	$106
D5671	Replace All Teeth & Acrylic on Cast Metal Framework - Mandibular	$106
D5710	Rebase Complete Maxillary Denture	$102
D5711	Rebase Complete Mandibular Denture	$102
D5720	Rebase Maxillary Partial Denture	$102
D5721	Rebase Mandibular Partial Denture	$102
D5730	Reline Complete Maxillary Denture (Chairside)	$62
D5731	Reline Complete Mandibular Denture (Chairside)	$62
D5740	Reline Maxillary Partial Denture (Chairside)	$60
D5741	Reline Mandibular Partial Denture (Chairside)	$60
D5750	Reline Complete Maxillary Denture (Laboratory)	$89
D5751	Reline Complete Mandibular Denture (Laboratory)	$89
D5760	Reline Maxillary Partial Denture (Laboratory)	$89
D5761	Reline Mandibular Partial Denture (Laboratory)	$89
D5850	Tissue Conditioning, Maxillary	$26
D5851	Tissue Conditioning, Mandibular	$26

ORTHODONTICS

Code	Procedure	Fee
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (age 18 and under) Class I and II	$3,241
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition (age 19 and over) Class I and II	$3,621
D8660	Pre-Orthodontic Treatment Visit	$205
D8680	Orthodontic Retention (Removal of Appliances, Construction & Placement Of Retainer(s))	$255

MISCELLANEOUS

Code	Procedure	Fee
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	$17
D9210	Local Anesthetic, Not in Conjunction with Operative Procs.	$0
D9215	Local Anesthesia-In Conjunction with Operative or Surgical Procedures (Inclusive in those Procedures)	$0
D9220	Deep Sedation/General Anesthesia-First 30 Minutes	$220
D9221	Deep Sedation/General Anesthesia-Each Additional 15 Minutes	$88
D9230	Analgesia, Nitrous Oxide	$12
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician	$26
D9430	Office Visit for Observation (During Regularly Scheduled Hours)	$5
D9440	Office Visit for Observation (After Regularly Scheduled Hours)	$5
D9450	Case Presentation, Detailed & Extensive Treatment Planning	$0
D9910	Application of Desensitizing Medicament, Per Visit	$7
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface-Per Tooth	$7
D9951	Occlusal Adjustment - Limited	$21
D9952	Occlusal Adjustment - Complete	$95

**Designated restorations include high noble metal (gold). The actual cost of this metal may be added to the patient's responsibility at the time of service. The payment responsibilities listed above are valid for the period of January 1, 2013 through December 31, 2013. They are subject to revision on January 1 of each year. A complete description of benefits, limitations and exclusions is included in your subscription certificate.*