Exhibit A-2
Prevea 360 MAPD - Summary and Certificate

Medicare Advantage Supplemental Dental Program

Welcome!

Your dental program is administered by Delta Dental of Wisconsin, Inc. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, Covered Code List and Evidence of Coverage, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call the Customer Care Center at 877-232-7566 (TTY Users call 711) or access Dean Health Plan's website at *prevea360.com/medicaremembers*.

You can easily verify your own benefit, claims and eligibility information online 24 hours a day, seven days a week by visiting *medicareadvantage.deltadentalwi.com* and selecting the link for our Member Portal. The Member Portal will also allow you to print claim forms and ID cards, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you!

TABLE OF CONTENTS

Note: Please read this Certificate together with the Summary of Dental Plan Benefits, Covered Code List and Evidence of Coverage. The Summary of Dental Plan Benefits and Covered Code List provides the specific provisions of your dental plan.

Dean Health Plan Prevea360 Supplemental Dental

Group Number: 6500-2006, 2011

Summary of Dental Plan Benefits

For Prevea360
Medicare Advantage Supplemental Dental Plan
Client Number 6500-2006, 2011

This Summary of Dental Plan Benefits should be read along with the Certificate, Covered Code List and Evidence of Coverage. These documents provide additional information about your Delta Dental plan, including information about plan exclusions and limitations. You may access these documents on the plan's website at prevea360.com/medicaremembers.

*Services received from dentists who do NOT participate in Delta Dental's Medicare Advantage Network are NOT covered benefits.

IMPORTANT: If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage Network YOU WILL BE RESPONSIBLE for the full cost of those services and no payment will be made by Delta Dental.

Control Plan – Delta Dental of Wisconsin

Benefit Year – January 1 through December 31, 2022

Covered Services –

	Delta Dental Medicare Advantage Dentist	Nonparticipating (out-of-network) Dentist
	Plan Pays	Plan Pays*
Diagnostic & Preventive Services ($0 Copay)		
Diagnostic and Preventive Services ** – two exams and two cleanings per calendar year	100%	0%
Radiographs – Bitewing X-rays (up to 4 images) are payable once per calendar year, Full mouth (including bitewing) and panoramic are payable once per five-year period	100%	0%
Fluoride treatment ** – to prevent tooth decay, payable once per calendar year	100%	0%
Comprehensive Services ($45 - $595 Copay)		
Emergency Palliative Treatment – to temporarily relieve pain	100%	0%
Minor Restorative Services – fillings (including tooth colored) and crown repair	100%	0%
Endodontic Services – root canals	100%	0%
Periodontal Services – to treat gum disease	100%	0%
Relines and Repairs – to bridges, implants and dentures	100%	0%
Extractions and Oral Surgery Services – extractions and dental surgery	100%	0%

Other Services – certain tests, anesthesia	100%	0%
Major Restorative Services – crowns and onlays, payable once per five year period	100%	0%
Prosthodontic Services – bridges, implants and dentures, payable once per five year period	100%	0%

** Members with cancer-related treatments, weakened immune systems, periodontal disease, high-risk cardiac conditions, kidney failure and diabetes may be eligible for up to two additional cleanings and one fluoride treatment per calendar year.

Maximum Payment – $1,500 per person total per Calendar Year on all services.

Copay – Please refer to the Covered Code List found in Section XII of this document to see the applicable copay per procedure.

Eligible People – All members enrolled in Prevea360 Medicare Advantage plans.

For enrollment and disenrollment information, please refer to your plan's Evidence of Coverage at prevea360.com/medicaremembers.

I. Delta Dental Certificate

Delta Dental of Wisconsin, Inc., referred to herein as Delta Dental, issues this Certificate to you, the Member. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and Dean Health Plan, your Medicare Advantage Organization.

The Benefits provided under This Plan may change if federal laws change.

Delta Dental agrees to provide Benefits as described in this Certificate, the Summary of Dental Plan Benefits, Covered Code List and Evidence of Coverage.

II. Definitions

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Allowed Amount

The amount permitted under the Medicare Advantage Dentist Fee Schedule which Delta Dental will base its payment for a Covered Service.

Appeal

The procedures that deal with the review of adverse initial determination for payment of services.

Benefit Year

The calendar year.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Certificate

This document. Delta Dental will provide Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the contract between Delta Dental and Dean Health Plan.

Completion Dates

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Coinsurance

The percentage of the charge, if any, that you must pay for Covered Services.

Copayment

A fixed amount of money that you must pay for Covered Services, if any.

Covered Code List

The unique list of the ADA dental codes that are covered services under This Plan. These codes are subject to the terms of this Certificate.

Covered Services

The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible

The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits and Evidence of Coverage lists the Deductible that applies to you, if any.

Delta Dental

Delta Dental of Wisconsin, Inc., which provides dental benefits. Delta Dental is not an insurance company. Delta Dental of

Wisconsin, Inc. has been delegated by Dean Health Plan to provide dental benefits for this plan.

Dental Emergency

A Dental Emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part.

Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- **Delta Dental Medicare Advantage Dentist -** a Dentist who has signed an agreement with Delta Dental for this Plan that is part of Delta Dental's Medicare Advantage Network.
- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with Delta Dental to become part of the Delta Dental Medicare Advantage Network. **Services received from Dentists who do NOT participate in Delta Dental's Medicare Advantage network are NOT covered benefits.**

IMPORTANT: If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage network YOU WILL BE RESPONSIBLE for the full cost of those services and no payment will be made by Delta Dental.

Grievance

An expression of dissatisfaction with any aspect of the operations, activities or behavior of Delta Dental, Dean Health or a Dentist that has provided dental services under this Plan.

Inquiry

A verbal or written request for information that does not involve a grievance, coverage, or appeals process, such as a routine question about a benefit.

Maximum Approved Fee

The maximum fee that Delta Dental approves for a given procedure in a given region and/or specialty, under normal circumstances, based upon applicable Medicare Advantage Participating Dentist schedules and internal procedures.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. (See the Summary of Dental Plan Benefits or Evidence of Coverage.)

Medicare Advantage Dentist Fee Schedule

The maximum fee allowed per procedure for services rendered by a Delta Dental Medicare Advantage Dentist as determined by Delta Dental.

Member

A person with coverage under This Plan.

Nonparticipating Dentist Fee

The most Delta Dental will pay Nonparticipating Dentists for a Covered Service.

Post-Service Claims

Claims for Benefits that are not conditioned on your seeking advance approval, certification, or authorization to receive the full amount for any Covered Services. In other words, Post-Service Claims arise when you receive the dental service or treatment before you file a claim for Benefits.

Pre-Service Organization Determination

A determination that is made prior to receiving dental services based on your benefits and coverage. This decision will determine whether a dental service will be covered and will provide information on how much you may have to pay for this service. This is a request submitted by you or your Dentist.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Service Organization Determinations and payment of claims. The Processing Policies may be amended from time to time.

Submitted Amount

The amount a Dentist bills to Delta Dental for a specific treatment or service. A Delta Dental Medicare Advantage Participating Dentist cannot charge you for the difference between this amount and the amount Delta Dental approves for the treatment.

Summary of Dental Plan Benefits

A description of the specific provisions of your dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

This Plan

The dental coverage established for you pursuant to this Certificate.

III. Selecting a Dentist

To receive benefits under This Plan you must receive services from a Delta Dental Medicare Advantage Dentist. Services received from Dentists who do NOT participate in Delta Dental's Medicare Advantage Network are not Covered Services.

To verify that a Dentist is a Medicare Advantage Participating Dentist, you can use Delta Dental's online Dentist Directory at medicareadvantage.deltadentalwi.com or call (877) 232-7566 (TTY Users call 711).

If the Dentist you select is not a Delta Dental Medicare Advantage Participating Dentist, services are not covered. You will be responsible for the full cost of the services and no payment will be made by Delta Dental.

The provider network may change at any time. You will receive notice when necessary.

IV. Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Certificate, the Summary of Dental Plan Benefits, Covered Code List and Evidence of Coverage carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental's Medicare Advantage Dental Plan. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, P.O. Box 9214, Farmington Hills, Michigan 48333, or calling the Customer Care Center toll-free number at (877) 232-7566.
3. After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:
   a. Your full name and address
   b. Your Prevea360 Member ID number
   c. Your date of birth

Notice of Claim Forms

Your Dentist should submit your dental claims form using the most recent American Dental Association ("ADA") approved claim form.

Medicare Advantage Participating Dentists will fill out and submit your dental claims for you.

Mail claims and completed information requests to:

Delta Dental
P.O. Box 9215
Farmington Hills, Michigan 48333

Pre-Service Organization Determination

Your Dentist can submit a request for a coverage decision to determine whether you qualify for a dental service that may be covered under This Plan through the Dental Office Toolkit ® (DOT). You can also request a coverage decision to determine whether you qualify for a dental service that may be covered under This Plan by calling the Customer Care Center toll-free at (877) 232-7566 or in writing at:

Delta Dental
P.O. Box 9215
Farmington Hills, MI 48333-9215

For a standard coverage decision, Delta Dental will provide an answer within 14 calendar days after receiving your request. To file a fast coverage decision the standard deadlines must potentially cause serious harm to your health or hurt your ability to function. If Delta Dental approves the fast request, an answer will be provided within 72 hours. For both standard and fast requests, Delta Dental may take up to 14 additional calendar days under certain circumstances. If additional time is taken, Delta Dental will notify you in writing and explain the reasons for the extension.

If Delta Dental does not approve your standard or fast coverage request, you have the right to file an appeal. Please see the Appeal section for more information. Availability of dental benefits at the time your request is completed is dependent on several factors. These factors include, but are not limited to, medical necessity, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. To determine whether a service may be covered under This Plan, please review the benefits included in this document.

Written Notice of Claim and Time of Payment

All claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a claim for payment is filed, Delta Dental will decide it within 30 days of receiving it. If there is not enough information to decide your claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the claim, and (d) inform you or your Dentist that the information must be received within 60 days or your claim will be denied. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it will decide your claim and send you notice of that decision. If you or your Dentist does not supply the requested information, Delta Dental will have no choice but to deny your claim. Once Delta Dental decides your claim, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Delta Dental on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue (see the Grievance and Appeals Procedure section). You should call the Customer Care Center, toll-free, at (877) 232-7566, or write Delta Dental at P.O. Box 9214, Farmington Hills, Michigan, 48333, to request a form to designate the person you wish to appoint as your representative or you may use the CMS Appointment of Representative Form (Form CMS-1696). While in some circumstances your Dentist is treated as your authorized representative, generally Delta Dental only recognizes the person whom you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate directly with you.

Questions and Assistance

Questions or Inquiries regarding your coverage should be directed to the Customer Care Center, at (877) 232-7566 (TTY Users call 711) (toll-free). You may also write to Delta Dental's Customer Service department at P.O. Box 9214, Farmington Hills, Michigan, 48333. When writing to Delta Dental, please include your name, your Dean Health Plan Member ID number, and your daytime telephone number.

V. How Payment is Made

If your Dentist is a Medicare Advantage Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to the Medicare Advantage Participating Dentists, and you will be responsible for any applicable Coinsurance, Copayments or Deductibles.

If the Dentist you select is not a Delta Dental Medicare Advantage Participating Dentist, services are NOT covered and no payment will be made by Delta Dental.

VI. Benefit Categories

Important

ONLY the dental services listed on your Summary of Dental Plan Benefits, the Covered Code List and Evidence of Coverage are covered by This Plan. Covered Services are also subject to exclusions and limitations. You will want to review this section of this Certificate carefully.

VII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits or Covered Code List. All charges for the same will be your responsibility (though your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible):

1. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
2. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
3. Services started or appliances started before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
4. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
5. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
6. Charges for hospitalization, laboratory tests, and histopathological examinations.
7. Charges for failure to keep a scheduled visit with the Dentist.
8. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
9. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
10. Services or supplies, as determined by Delta Dental, which are specialized techniques.
11. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional, as determined by Delta Dental, under the scope of his or her license as permitted by applicable state law.
12. Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
13. Services or supplies received due to an act of war, declared or undeclared.
14. Services or supplies covered under a hospital, surgical/medical, (including Medicare Advantage), or prescription drug program.
15. Services or supplies that are not within the categories of Benefits selected by your Medicare Advantage Organization and that are not covered under the terms of this Certificate.
16. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
17. Interim caries arresting medicament.
18. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control,

tobacco counseling, home care medicaments, etc.).

19. Sealants.
20. Space maintainers.
21. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
23. Veneers.
24. Prefabricated crowns used as final restorations on permanent teeth.
25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the contract between Delta Dental and your employer or organization.
26. Implant/abutment supported interim fixed denture for edentulous arch.
27. Soft occlusal guard appliances.
28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments of occlusal guards.
30. Chemical curettage.
31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.
34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch.
37. Precision attachments and stress breakers.
38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
39. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
40. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
41. Orthodontic Services.
42. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
43. Myofunctional therapy.
44. Mounted case analyses.
45. Any and all taxes applicable to the services.
46. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Medicare Advantage Participating Dentists may not charge Members for these services or supplies. All charges from Nonparticipating Dentists for the following are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of claims.

3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Local anesthesia.
5. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
6. Infection control.
7. Temporary, interim, or provisional crowns.
8. Gingivectomy as an aid to the placement of a restoration.
9. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
10. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
11. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
12. Post-operative X-rays, when done following any completed service or procedure.
13. Periodontal charting.
14. Pins and preformed posts, when done with core buildups for crowns, onlays, or inlays.
15. Any substructure when done for inlays, onlays and veneers.
16. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
17. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
18. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
19. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
20. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
21. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
22. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
23. Full mouth debridement when done within 30 days of scaling and root planing.
24. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
26. Full mouth debridement, when done on the same day as comprehensive evaluation.
27. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
28. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.

29. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
30. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.
31. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
32. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits, Covered Code List and Evidence of Coverage. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan or, at the request of Dean Health Plan, any dental plan:

1. Bitewing x-rays are payable once every calendar year, unless a full mouth X-ray which include bitewings has been paid in that same year.
2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period.
3. Any combination of teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of gingival inflammation, and periodontal maintenance are payable twice per calendar year. Full mouth debridement is payable once in a lifetime. Members may be eligible for up to 2 additional cleanings if certain medical conditions are present. Please refer to your health plans' Evidence of Coverage for more information.
4. Oral examinations and evaluations (not included limited problem focused evaluations or patient screenings) are only payable twice per calendar year, regardless of the Dentist's specialty.
5. Patient screening is payable once per calendar year.
6. Preventive fluoride treatments are payable once per calendar year with no age limit. Members may be eligible for up to one additional fluoride treatment if certain medical conditions are present. Please refer to your health plans' Evidence of Coverage for more information.
7. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth. Subsequent minor restorations would not be a benefit within that five-year period.
8. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
9. Individual crowns over implants are payable at the prosthodontic benefit level once in a five year period.
10. Hard full or partial arch occlusal guards are payable once in a lifetime.
11. An interim partial denture is payable only during the healing period for people age 17 and over.
12. Assessments of salivary flow by measurement are payable once in any 36-month period.
13. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period.
14. Prosthodontic Services limitations:
    a. Once complete upper and one complete lower denture, and any implant used to support a denture,

are payable once in any five-year period.

b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.

c. A removable unilateral partial denture is payable once per quadrant in any 5 year period unless the loss of additional teeth requires the construction of a new appliance.

d. A reline or complete replacement of denture base material is payable once in any three-year period per appliance.

e. Implant removal is payable once per lifetime per tooth or area.

f. Implant maintenance is payable once per any twelve (12) month period.

g. Removal of a broken implant retaining screw is payable once in a 5 year period.

15. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. This date is usually the first of the month following receipt of a valid, written request to disenroll that was accepted by your plan during a valid Medicare election period. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a claim for those services within one year of the date of service.

16. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.

17. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

a. Resin, porcelain fused to metal, and porcelain crowns, bridge retainers, or pontics on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.

b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.

c. Resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.

d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.

e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.

f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.

g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.

h. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.

18. Maximum Payment:

    a. All benefits available under This Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits and Evidence of Coverage.

19. If a Deductible amount is stated in the Summary of Dental Plan Benefits and Evidence of Coverage, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.

20. Processing Policies may limit Delta Dental's payment for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Medicare Advantage Participating Dentists may not charge Eligible Persons for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan or, at the request of your Dean Health Plan dental plan:

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue Conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
12. One assessment of salivary flow by measurement is allowed within a twelve (12) month period when done by the same Dentist/dental office.
13. Processing Policies may limit Delta Dental's payment for services or supplies.

VIII. Coordination of Benefits

The Coordination of Benefits ("COB") provision applies when a Person has health care coverage under more than one plan. "Plan" is defined below.

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 does not exceed 100 percent of the total Allowable Expense.

Definitions

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 and non-group insurance contracts, 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; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; or coverage under other federal governmental plans that do not permit coordination.

Each contract for coverage under (1) or (2) above 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.

This Plan, for purposes of this section, means 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.

Order of Benefit Determination Rules determines 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 the total benefits payed by all Plans do not exceed the Submitted Amount. In no event will This Plan's payments exceed the Maximum Approved Fee.

Order of Benefits Determination Rules

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

1. This Plan will pay primary over any Medicaid or Retiree Plan that you may have.
2. This Plan will pay secondary to any employer sponsored, automobile, group, or individual Plan you may have, except for those listed in (1) above.
3. If This Plan is the Primary Plan, it will pay its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
4. Except as provided in the following paragraph, a Plan that does not contain a COB provision is always primary unless otherwise required by law.

   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, shall be secondary regardless of whether or not it contains a COB provision.
5. 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.

Effect on the Benefits of This Plan

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 Submitted Amount. In determining the amount to be paid, This Plan will calculate the benefits it would have paid in the absence of other health care coverage (Maximum Approved Fee) and apply that the remaining amount that you owe to the Dentist following the Primary Plan's payment. The amount paid by This Plan will not exceed the Maximum Approved Fee.

Right of Recovery

If the amount of the payments made by Delta Dental 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.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. You or your Dentist should contact the Customer Care Center and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, (877) 232-7566, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at PO Box 9214, Farmington Hills, Michigan, 48333. You may also follow the Grievance and Appeals Procedure below

IX. Grievance and Appeal Procedures

If we make an Adverse Benefit Determination, you will receive a Notice of Denial of Coverage. You, or your authorized representative, should seek a review as soon as possible, but you must file your request for review within **60 days** of the date that you received that Notice of Denial of Coverage. Delta Dental may give you more time if you have a good reason for missing the deadline.

There are two types of appeals.

Standard Appeal – We will give you a written decision on a standard appeal within 30 days after we get your appeal for a Pre-Service Organization Determination. Our decision might take longer if you ask for an extension, or if we need more information about your case. We will tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you have already received, we will give you a written decision within 60 days.

Fast Appeal – We will give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 Days for a decision. You cannot request a fast appeal if you are asking us to pay you back for a service you have already received.

Send appeals to the following:

Delta Dental
Attn: Dental Director
P.O. Box 9214
Farmington Hills, MI 48333

Fax: 517-381-5527

Phone: 877-232-7566

TTY: 711

Please include your name and address, the Dean Health Plan Member ID, the explanation of benefits, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. Indicate in your letter that you are requesting a formal Appeal (Standard/Fast Appeal) of your claim. You also have the right to review any documents related to your Appeal. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

If you want someone else to act for you, you can name a relative, friend, attorney, dentist or someone else to act as your representative. You can do this by following the Authorized Representative section above. Both you and the person you want to act for

you must sign and date a statement confirming this is what you want. You will need to mail or fax the statement to Delta Dental at the address above.

The Dental Director or any person reviewing your claim will not be the same as, nor subordinate to, the person(s) who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim even if the information was not available when your claim was initially decided.

The notice of any adverse determination regarding your Appeal will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provision(s) on which the denial is based, (c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review.

Adverse Appeals will be automatically submitted to the CMS's contracted independent review entity within 60 calendar days from the date Delta Dental received the member's first level appeal. Delta Dental will concurrently notify the member that the Appeal is being forwarded to CMS's independent review entity.

If you have a complaint or dispute, other than a Notice of Denial of Coverage, expressing dissatisfaction with the manner in which Delta Dental or a dentist has provided dental services, you can contact Delta Dental at the address listed above in this section or by calling the Customer Care Center, toll free, at (877) 232-7566 (TTY: 711) within 60 days of the event. Delta Dental will respond in writing to all Grievances within 30 days of receipt, unless issue is resolved by customer service when you call.

X. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- When Dean Health Plan advises Delta Dental to terminate your coverage.
- On the first day of the month for which Dean Health Plan has failed to pay Delta Dental.
- For fraud or misrepresentation in the submission of any claim.
- For any other reason stated in the contract between Delta Dental and Dean Health Plan.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by Dean Health Plan. A person whose eligibility is terminated may not continue coverage under this Certificate

XI. General Conditions

Subrogation and Right of Reimbursement

If you are involved in an automobile accident or require Covered Services that may entitle you to recover from a third party and Delta Dental advances payment to prevent any financial hardship, you have an obligation to help Delta Dental obtain reimbursement for the amount of the payments advanced for which another source was also responsible for making payment. You are required to provide Delta Dental with any information about any other insurance coverage (including, but not limited to, automobile, home, and other liability insurance coverage, and coverage under another group health plan), and the identity of any other person or entity, and his or her insurers (if known), that may be obligated to provide payments or benefits for the same Covered Services that Delta Dental already paid.

You must:

1. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
2. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta

Dental, or not including Delta Dental as a co-payee of any settlement amount),

3. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
4. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information

You agree to provide Delta Dental with any information it needs to process your claims and administer your Benefits. This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

You are free to choose any Dentist. Each Dentist maintains the dentist-patient relationship and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment

If you lose eligibility while receiving dental treatment, only Covered Services received while you are covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a claim for such has not been received by Delta Dental within one year following the date the services or supplies were completed.

Change of Certificate or Contract

No agent has the authority to change any provisions in this Certificate or the provisions of the contract on which it is based. No changes to this Certificate or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

No action on a legal claim arising out of or related to this Certificate will be brought within 60 days after notice of the legal claim has been given to Delta Dental, unless prohibited by applicable state law. In addition, no action can be brought more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, if longer. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Governing Law

This Certificate and the underlying group contract will be governed by and interpreted under Centers for Medicare and Medicaid (CMS).

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to your acts, it may recover that payment from you. You authorize Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from

any payments properly due to you. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application or files a claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

(800) 524-0147 (TTY Users call 711)

This section provides a list of dental procedures covered by your plan. If a procedure is not on this list, it is not a standard covered benefit under your plan. Standard benefit limitations under these programs are listed where applicable in the Benefit Limitations column. Some services share frequencies. Additional information on the frequency limitations can be found in Section VII of your Delta Dental Certificate.

*Please note, procedures in the following code ranges may require routine review or diagnostic information such as radiographs or patient treatment records for claims processing and final payment determinations: D0220-D0250, D0999; D2710-D2794, D2910-D2934, D1999 Preventive; D2950-D2999 Restorative; D3000-D3999 Endodontics; D4000-D4999 Periodontics; D5110-D5671, D5875-D5999 Prosthodontics (Removable); D6000-D6199 Implant Services; D6200-D6999 Prosthodontics (Fixed); D7111-7999 Oral and Maxillofacial Surgery; D9120, D9310, D9410, D9420, D9930 and D9999 Adjunctive Services

**Please note, members may be eligible for additional services if certain medical conditions are present. Please refer to your health plans' Evidence of Coverage for more information.

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Copay per Procedure	Benefit Limitations
D0100-D0999 Diagnostic					
D0120	periodic oral evaluation - established patient	100%	0%	$0	Twice per calendar year
D0140	limited oral evaluation - problem focused	100%	100%	$0	As needed for diagnosis of emergency condition
D0150	comprehensive oral evaluation - new or established patient	100%	0%	$0	Once per 36 months
D0160	detailed and extensive oral evaluation - problem focused, by report	100%	0%	$0	Once per 36 months
D0180	comprehensive periodontal evaluation - new or established patient	100%	0%	$0	Once per calendar year
D0190	screening of a patient	100%	0%	$0	Once per calendar year
D0210	intraoral - complete series	100%	0%	$0	Once per 5 year period
D0220*, D0230*, D0240*, D0250*	Intraoral/extra-oral - periapical image, occlusal image	100%	0%	$0	Covered service

D0270, D0272, D0273, D0274, D0277	bitewing x-rays	100%	0%	$0	Once per calendar year
D0330	panoramic image	100%	0%	$0	Once per 5 year period
D0419	assessment of salivary flow, by measurement	100%	0%	$0	Once per 3 year period
D0460	pulp vitality tests	100%	0%	$0	Payable per visit not per tooth for the diagnosis of emergency conditions
D0999*	unspecified diagnostic procedure, by report	100%	0%	$0	Benefit determined by consultant review
D1000-D1999 Preventive					
D1110**	prophylaxis - adult	100%	0%	$0	Twice per calendar year; two additional cleanings per calendar year for members with specific health conditions.
D1206**, D1208**	topical application of fluoride	100%	0%	$0	Once per calendar year; one additional treatment per calendar year for members with specific health conditions
D1999*	unspecified preventive procedure, by report	100%	0%	$0	Benefit determined by consultant review
D2000-D2999 Restorative					

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390	amalgam – and composite resin	100%	0%	$95	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface
D2391, D2392, D2393, D2394	resin-based composite - posterior	100%	0%	$95	Amalgam and composite resin restorations are payable once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface
D2410, D2420, D2430	gold foil	Optional	0%	$95	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2140, D2150, D2160)
D2510, D2520, D2530,	inlay - metallic	Optional	0%	$95	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2140, D2150, D2160, D2161)
D2542 D2543, D2544	onlay - metallic	100%	0%	$595	Once per 5 year period

D2610, D2620, D2630	inlay - porcelain/ceramic	Optional	0%	$95	Plan will pay only the applicable amount that it would have paid for a composite restoration (D2330, D2331, D2335, D2391, D2392, D2393)
D2642, D2643, D2644, D2662, D2663, D2664	onlay - porcelain/ceramic or resin-based	100% / Optional	0%	$595	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a metallic onlay (D2542, D2543, D2544)
D2650, D2651, D2652	inlay - resin-based composite	Optional	0%	$95	Plan will pay only the applicable amount that it would have paid for a composite restoration (D2330, D2331, D2335 or D2391, D2392, D2393)
D2710* D2712*, D2720*, D2721*, D2722*, D2740*, D2750*, D2751*, D2752*, D2753*, D2783*	crown - resin-based composite or porcelain/ceramic	100% / Optional	0%	$595	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal crown (D2781, D2790, D2791, D2792, D2794)
D2780* D2781*, D2782*	crown - 3/4 cast	100%	0%	$595	Once per 5 year period

D2790*, D2791*, D2792*, D2794*	crown - full cast	100%	0%	$595	Once per 5 year period
D2910*	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	100%	0%	$45	Covered service
D2915*	re-cement or re-bond indirectly fabricated or prefabricated post and core	100%	0%	$45	Covered service
D2920*	re-cement or re-bond crown	100%	0%	$45	Covered service
D2921*	reattachment of tooth fragment, incisal edge or cusp	100%	0%	$45	Covered service
D2928*, D2929*, D2930*, D2931*, D2932*, D2933*, D2934*	prefabricated crown	100%	0%	$45	Covered service
D2940	protective restoration	100%	0%	$45	Once per tooth per lifetime and considered to be part of the fee when done in conjunction with a definitive restoration, indirect pulp cap or endodontic treatment (including pulpotomy)
D2941	interim therapeutic restoration - primary dentition	100%	0%	$45	Once per primary tooth
D2950*	core buildup, including any pins when required	100%	0%	$45	Once per 5 year period
D2951*	pin retention - per tooth, in addition to restoration	100%	0%	$45	Once per tooth per lifetime
D2952*, D2954*	post and core in addition to crown	100%	0%	$45	Once per 5 year period
D2955*	post removal	100%	0%	$45	Covered service
D2971*	additional procedures to construct new crown under existing partial denture framework	100%	0%	$45	Covered service

D2980*, D2981*, D2982*, D2983*	repair necessitated by restorative material failure	100%	0%	$45	Covered service
D2999*	unspecified restorative procedure, by report	100%	0%	$45	Benefit determined by consultant review
D3000-D3999 Endodontics					
D3220*	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	100%	0%	$45	Covered service
D3221*	pulpal debridement, primary or permanent teeth	100%	100%	$45	Covered service
D3222*	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	100%	0%	$45	Once per tooth per lifetime; additional benefit will require review
D3230*, D3240*	pulpal therapy (resorbable filling) - any tooth (excluding final restoration)	100%	0%	$45	Covered service
D3310*, D3320*, D3330*	endodontic therapy, (excluding final restoration)	100%	0%	$595	Covered service
D3332*	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	100%	0%	$45	Covered service
D3333*	internal root repair of perforation defects	100%	0%	$45	Covered service
D3346*, D3347*, D3348*	retreatment of previous root canal therapy	100%	0%	$595	Covered service
D3351, D3352*, D3353*	apexification/recalcification (apical closure/calcific repair of perforations, root resorption, root canal, pulp space, disinfection etc.)	100%	0%	$45	Covered service
D3410*, D3421*, D3425*	apicoectomy	100%	0%	$595	Covered service
D3426*	apicoectomy (each additional root)	100%	0%	$45	Covered service
D3430*	retrograde filling - per root	100%	0%	$45	Covered service
D3450*	root amputation - per root	100%	0%	$45	Covered service
D3471*, D3472*, D3473*	surgical repair of root resorption	100%	0%	$45	Covered service

D3501*, D3502*, D3503*	surgical exposure of root surface with apicoectomy or repair of root resorption	100%	0%	$45	Covered service
D3920*	hemisection (including any root removal), not including root canal therapy	100%	0%	$45	Covered service
D3999*	unspecified endodontic procedure, by report	100%	0%	$45	Benefit determined by consultant review
D4000-D4999 Periodontics					
D4210*, D4211*	gingivectomy or gingivoplasty	100%	0%	$95	Once per 36 month period
D4240*, D4241*	gingival flap procedure, including root planing	100%	0%	$595	Once per 36 month period
D4245*	apically positioned flap	100%	0%	$595	Covered service
D4249*	clinical crown lengthening - hard tissue	100%	0%	$595	Once per tooth per 24 month period
D4260*, D4261*	osseous surgery (including elevation of a full thickness flap and closure)	100%	0%	$595	Once per 36 month period
D4263*	bone replacement graft - retained natural tooth - first site in quadrant	100%	0%	$595	Once per 36 month period
D4264*	bone replacement graft - retained natural tooth - each additional site in quadrant	100%	0%	$95	Once per 36 month period
D4265*	biologic materials to aid in soft and osseous tissue regeneration	100%	0%	$95	Once per 36 month period
D4266*, D4267*	guided tissue regeneration -	100%	0%	$95	Once per 36 month period
D4268*	surgical revision procedure, per tooth	100%	0%	$95	Once per 36 month period
D4270*	pedicle soft tissue graft procedure	100%	0%	$95	Once per 36 month period
D4273*, D4277*, D4278*	free soft tissue graft procedure (including recipient and donor site surgery)	100%	0%	$95	Once per 36 month period
D4274*	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	100%	0%	$95	Covered service

D4275*	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	100%	0%	$95	Once per 36 month period
D4276* D4283*, D4285*	connective tissue graft (including recipient site and donor material)	100%	0%	$95	Once per 36 month period
D4341*, D4342*	periodontal scaling and root planing	100%	0%	$45	No more than 2 quadrants of scaling and root planing on the same date of service
D4346*	scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	100%	0%	$45	Including in the cleaning frequency of twice per calendar year
D4355*	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	100%	0%	$45	Once per lifetime
D4910*	periodontal maintenance	100%	0%	$45	Including in the cleaning frequency of twice per calendar year
D4999*	unspecified periodontal procedure, by report	100%	0%	$45	Benefit determined by consultant review
D5000-D5899 Prosthodontics (Removable)					
D5110*, D5120*, D5130*, D5140*	Complete/immediate denture	100%	0%	$595	Once per five-year period
D5211*, D5212*, D5213*, D5214*	partial denture - resin base (including retentive/clasping materials, rests and teeth)	100%	0%	$595	Once per five-year period
D5221*, D5222*, D5223*, D5224*	immediate partial denture - resin base (including any retentive/clasping materials, rests and teeth)	100%	0%	$595	Once per five-year period
D5225*, D5226*	partial denture - flexible base (including retentive/clasping materials, rests and teeth)	100%	0%	$595	Once per five-year period

D5282*, D5283*, D5284*, D5286*	removable unilateral partial denture (including retentive/clasping materials, rests and teeth)	100%	0%	$595	Once per five-year period
D5410*, D5411*, D5421*, D5422	adjust complete/partial denture	100%	0%	$45	Covered service

D5511*, D5512*, D5611*, D5612*, D5621*, D5622*, D5630*	repair broken complete or partial denture	100%	0%	$45	Covered service
D5520	replace missing or broken teeth - complete denture (each tooth)	100%	0%	$45	Covered service
D5640	replace broken teeth - per tooth	100%	0%	$45	Covered service
D5650	add tooth to existing partial denture	100%	0%	$45	Covered service
D5660	add clasp to existing partial denture - per tooth	100%	0%	$45	Covered service
D5670* D5671*	replace all teeth and acrylic on cast metal framework	100%	0%	$45	Covered service
D5710, D5711, D5720, D5721	rebase complete or partial denture	100%	0%	$45	Once per 36 month period
D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	reline complete or partial denture	100%	0%	$45	Once per 36 month period
D5820 D5821	interim partial denture	100%	0%	$95	Payable for the replacement of permanent anterior teeth during the healing period
D5850, D5851	tissue conditioning	100%	0%	$45	Twice per 36 month period
D5863, D5864, D5865, D5866	overdenture – complete or partial	Optional	0%	$595	Plan will pay only the applicable amount that it would have paid for a conventional full denture (D5110, D5120, D5211, D5212)
D5875*	modification of removable prosthesis following implant surgery	100%	0%	$45	Subject to review

D5899*	unspecified removable prosthodontic procedure, by report	100%	0%	$45	Benefit determined by consultant review
D5931*	obturator prosthesis, surgical	100%	0%	$95	Subject to review
D5999*	unspecified maxillofacial prosthesis, by report	100%	0%	$95	Benefit determined by consultant review
D6000-D6199 Implant Services					
D6010*	surgical placement of implant body; endosteal implant	100%	0%	$595	Once per 5 year period
D6013*	surgical placement of mini implant	100%	0%	$595	Once per 5 year period
D6056*	prefabricated abutment - includes modification and placement	100%	0%	$595	Once per 5 year period
D6057*	custom abutment - includes placement	100%	0%	$595	Once per 5 year period
D6058*, D6059*, D6060*, D6061*, D6062*, D6063*, D6064*	abutment supported crown, any material	100%	0%	$595	Once per 5 year period
D6065*, D6066*, D6067*, D6082*, D6083*, D6084*, D6086*, D6087*, D6088*	implant supported crown, any material	100%	0%	$595	Once per 5 year period
D6068*, D6069*, D6070*, D6071*, D6072*, D6073*, D6074*	abutment supported retainer for FPD	100%	0%	$595	Once per 5 year period
D6075*, D6076,* D6077*	implant supported retainer for FPD	100%	0%	$595	Once per 5 year period
D6080*	implant maintenance procedures - when prostheses are removed and reinserted, including cleansing of prostheses and abutments	100%	0%	$45	Once per 12 month period

D6081*	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	100%	0%	$45	Once per 24 month period
D6090*	repair implant supported prosthesis, by report	100%	0%	$45	Covered service
D6092*, D6093*	recement implant/abutment supported crown or fixed partial denture	100%	0%	$45	Covered service
D6094*, D6097*	abutment supported crown	100%	0%	$595	1 per 5 year period
D6095*	repair implant abutment, by report	100%	0%	$45	Covered service
D6096*	remove broken implant retaining screw	100%	0%	$45	1 per 5 year period
D6098*	implant supported retainer - porcelain fused to predominantly based alloys	100%	0%	$595	1 per 5 year period
D6099*	implant supported retainer for FPD - porcelain fused to noble alloys	100%	0%	$595	1 per 5 year period
D6100*	implant removal, by report	100%	0%	$595	Once per tooth per lifetime
D6101*	debridement of a peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	100%	0%	$595	Covered service
D6102*	debridement and osseous contouring of a peri-implant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure	100%	0%	$595	Covered service
D6110*, D6111*, D6112*, D6113*, D6114*, D6115*, D6116*, D6117*	implant/abutment supported removable or fixed denture	Optional	0%	$595	Plan will pay only the applicable amount that it would have paid for a conventional full denture (D5110, D5120, D5211-D5214)

D6120*	implant supported retainer - porcelain fused to titanium and titanium alloys	100% / Optional	0%	$595	1 per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal implant supported retainer (D6123)
D6121*, D6122*, D6123*	implant supported retainer for metal FPD	100%	0%	$595	Once per 5 year period
D6194*	abutment supported retainer crown for FPD - titanium and titanium alloys	100%	0%	$595	Once per 5 year period
D6195*	abutment supported retainer - porcelain fused to titanium and titanium alloys	100% / Optional	0%	$595	Once per 5 year period
D6199*	unspecified implant procedure, by report	100%	0%	$595	Benefit determined by consultant review
D6200-D6999 Prosthodontics (Fixed)					
D6205*, D6245*	pontic - indirect resin based composite or porcelain/ceramic	Optional	0%	$595	Benefits may be considered for a conventional fixed prosthesis
D6210*, D6211*, D6212*, D6214*	pontic	100%	0%	$595	Once per 5 year period
D6240*, D6241*, D6242*, D6243*	pontic - porcelain fused	100% / Optional	0%	$595	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal pontic (D6210, D6211, D6212, D6214)

D6250*, D6251*, D6252*	pontic - resin	100% / Optional	0%	$95	Once per 5 year period; Optional service on posterior teeth. Plan will pay only the applicable amount that it would have paid for a full metal pontic (D6211, D6212, D6214)
D6545*	retainer - cast metal for resin bonded fixed prosthesis	100%	0%	$95	Once per 5 year period per consultant review
D6548*	retainer - porcelain/ceramic for resin bonded fixed prosthesis	Optional	0%	$595	Benefits may be considered for a conventional fixed prosthesis
D6549*	resin retainer - for resin bonded fixed prosthesis	Optional	0%	$595	Benefits may be considered for a conventional fixed prosthesis
D6600*, D6601*	retainer inlay - porcelain/ceramic	Optional	0%	$595	Plan will pay only the applicable amount that it would have paid for a full metal inlay (D6602, D6603)
D6602*, D6603*	retainer inlay - cast high noble metal	100%	0%	$595	Once per 5 year period per consultant review
D6604*, D6605*	retainer inlay - cast predominantly base metal,	100%	0%	$595	Once per 5 year period per consultant review
D6606*, D6607*	retainer inlay - cast noble metal	100%	0%	$595	Once per 5 year period per consultant review

D6608*, D6609*	retainer onlay - porcelain/ceramic	Optional	0%	$95	Plan will pay only the applicable amount that it would have paid for a full metal onlay (D6610, D6611)
D6610*, D6611*	retainer onlay - cast high noble metal	100%	0%	$95	Once per 5 year period per consultant review
D6612*, D6613*	retainer onlay - cast predominantly base metal,	100%	0%	$95	Once per 5 year period per consultant review
D6614*, D6615*	retainer onlay - cast noble metal	100%	0%	$95	Once per 5 year period per consultant review
D6624*	retainer inlay - titanium	100%	0%	$95	Once per 5 year period per consultant review
D6634*	retainer onlay - titanium	100%	0%	$95	Once per 5 year period per consultant review
D6710*	retainer crown - indirect resin based composite	Optional	0%	$595	Benefits may be considered for a conventional fixed prosthesis
D6720*, D6721*, D6722*	retainer crown - resin	100% / Optional	0%	$595	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal retainer crown (D6790, D6791, D6792)
D6740*	retainer crown - porcelain/ceramic	Optional	0%	$595	Benefits may be considered for a conventional fixed prosthesis

D6750*, D6751*, D6752*, D6753*	retainer crown - porcelain fused	100% / Optional	0%	$595	Once per 5 year period; Optional service on posterior teeth. Plan will pay only the applicable amount that it would have paid for a full metal retainer crown (D6790, D6791, D6792, D6794)
D6780*, D6781*, D6782*, D6784*	retainer crown - 3/4 cast	100%	0%	$595	Once per 5 year period per consultant review
D6783*	retainer crown - 3/4 porcelain/ceramic	Optional	0%	$595	Plan will pay only the applicable amount that it would have paid for a full metal retainer crown
D6790*, D6791*, D6792*, D6794*	retainer crown - full cast	100%	0%	$595	Once per 5 year period per consultant review
D6930*	re-cement or re-bond fixed partial denture	100%	0%	$45	Covered service
D6980*	fixed partial denture repair, necessitated by restorative material failure	100%	0%	$45	Covered service
D6999*	unspecified fixed prosthodontic procedure, by report	100%	0%	$45	Benefit determined by consultant review
D7000-D7999 Oral and Maxillofacial Surgery					
D7111*	extraction, coronal remnants - primary tooth	100%	0%	$95	Once per tooth per lifetime
D7140*	extraction, erupted tooth or exposed root (elevation and or forceps removal)	100%	0%	$95	Once per tooth per lifetime
D7210*	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated	100%	0%	$95	Once per tooth per lifetime

D7220*, D7230*, D7240*	removal of impacted tooth	100%	0%	$95	Once per tooth per lifetime
D7241*	removal of impacted tooth - completely bony, with unusual surgical complications	100%	0%	$95	Once per tooth per lifetime
D7250*	removal of residual tooth roots (cutting procedure)	100%	0%	$95	Once per tooth per lifetime
D7251*	coronectomy - intentional partial tooth removal	100%	0%	$95	Once per tooth per lifetime
D7270*	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	100%	0%	$95	Covered service
D7280*	exposure of an unerupted tooth	100%	0%	$95	Once per tooth per lifetime
D7282	mobilization of erupted or malpositioned tooth to aid eruption	100%	0%	$95	Once per tooth per lifetime
D7283*	placement of device to facilitate eruption of impacted tooth	100%	0%	$95	Covered service
D7286*	biopsy of oral tissue - soft	100%	0%	$95	Subject to services it is performed in conjunction with. Predeterminati on is strongly recommended.
D7290*	surgical repositioning of teeth	100%	0%	$95	Covered service
D7291*	transseptal fiberotomy/supra crestal fiberotomy, by report	100%	0%	$95	Covered service
D7310*, D7311*	alveoloplasty in conjunction with extractions	100%	0%	$95	Covered service
D7320*, D7321*	alveoloplasty not in conjunction with extractions	100%	0%	$95	Covered service
D7510*	incision and drainage of abscess - intraoral soft tissue	100%	0%	$95	Covered service
D7511*	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	100%	0%	$95	Covered service
D7910*	suture of recent small wounds up to 5 cm	100%	0%	$95	Covered service
D7970*	excision of hyperplastic tissue - per arch	100%	0%	$95	Covered service
D7971*	excision of pericoronal gingiva	100%	0%	$95	Covered service

D7999*	unspecified oral surgery procedure, by report	100%	0%	$95	Benefit determined by consultant review
D9000-D9999 Adjunctive General Services					
D9110	palliative (emergency) treatment of dental pain - minor procedure	100%	100%	$45	As needed for diagnosis of emergency condition
D9120*	fixed partial denture sectioning	100%	0%	$45	Covered service
D9222, D9223	deep sedation/general anesthesia	100%	0%	$45	Paid in conjunction with qualifying services
D9239, D9243	intravenous moderate (conscious) sedation/analgesia	100%	0%	$45	Paid in conjunction with qualifying services
D9310*	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	100%	0%	$45	Covered service
D9410*	house/extended care facility call	100%	0%	$45	Requires consultant review
D9420*	hospital or ambulatory surgical center call	100%	0%	$45	Requires consultant review
D9440	office visit - after regularly scheduled hours	100%	0%	$0	As needed for diagnosis of emergency condition
D9930*	treatment of complications (post-surgical) - unusual circumstances, by report	100%	0%	$45	Covered service
D9944, D9946	occlusal guard - hard appliance	100%	0%	$45	Once per lifetime
D9951	occlusal adjustment - limited	100%	0%	$45	Payable three times in a five-year period
D9952	occlusal adjustment - complete	100%	0%	$45	Payable once in a five-year period
D9999*	unspecified adjunctive procedure, by report	100%	0%	$45	Benefit determined by consultant review