CONTRACTHOLDER: EMPLOYEES RETIREMENT SYSTEM OF TEXAS (“ERS”)
GROUP NUMBER: 424546
COVERAGE EFFECTIVE DATE: 9/1/2026

The entity providing coverage is
A DENTAL HEALTH MAINTENANCE ORGANIZATION

COMPBENEFITS

Offered and administered by DentiCare, Inc. (d/b/a as CompBenefits),
a Humana Company
1100 Employers Blvd.
Green Bay, WI 54344
(855) 756-6580
www.ERSdentalplans.com

EVIDENCE OF COVERAGE (EOC)

Please see the attached Schedule of Benefits at the back of this EOC for the list of covered services and copayments applicable to your plan.

TABLE OF CONTENTS

Have a complaint or need help?

If you have a problem with a claim or your premium, call DentiCare, Inc. (d/b/a as CompBenefits) first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through DentiCare, Inc. (d/b/a as CompBenefits). If you don't, you may lose your right to appeal.

DentiCare, Inc. (d/b/a as CompBenefits)

To get information or file a complaint with DentiCare, Inc. (d/b/a as CompBenefits):

Call: Customer Care at (855) 756-6580
Toll Free: (855) 756-6580
Mail: Humana Grievance and Appeal Department
P.O. Box 14163
Lexington, KY 40512-4163

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: (800) 252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a DentiCare, Inc. (d/b/a as CompBenefits). Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de DentiCare, Inc. (d/b/a as CompBenefits).Si no lo hace, podría perder su derecho para apelar.

DentiCare, Inc (d/b/a as CompBenefits)

Para obtener información o para presentar una queja ante DentiCare, Inc. (d/b/a as CompBenefits).

Llame a: Customer Care at (855) 756-6580
Teléfono gratuito: (855) 756-6580
Dirección postal: Humana Grievance and Appeal Department
P.O. Box 14163
Lexington, KY 40512-4163

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: (800) 252-3439

Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

DEFINITIONS

Act is The Texas Employees Group Benefits Act (Chapter 1551 of the *Texas Insurance Code*).

Appeal is the formal process by which the Plan offers the Participant a mechanism to request a secondary review of a complaint resolution.

Benefits are those Covered Dental Care Services available to the Participants as stated in their EOC and Schedule of Benefits.

Complaint is a verbal or written expression of dissatisfaction with the Plan, regarding any aspect of the Plan's operations. It does not include an Appeal or a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Participant.

Contractholder or ERS means the party that has entered into a Contractual Agreement for Covered Dental Care Services.

Contributions are those periodic payments due Plan by Contractholder to receive Benefits as provided by the EOC and Schedule of Benefits.

Copayment is the dollar amount the Participant is required to pay when receiving Covered Dental Care Services.

Covered Dental Care Services are those services to be performed by a Participating General Dentist or Participating Specialty Dentist pursuant to the terms of this EOC and a Participating General Dentist Agreement or a Participating Specialty Dentist Agreement. To be covered by Plan, services must be (a) necessary; and (b) appropriate for the given condition.

Dental Facility is any location which the Participating General Dentist or Participating Specialist have established, or contractually arranged to provide Dental Care Services to Participants.

Dependent means an individual who, because of a statutorily defined relationship with You is or becomes eligible for Covered Dental Care Services under the Group Benefits Program ("GPB") through ERS.

Effective Date is the first day that a Participant is entitled to receive Benefits designated in the EOC.

Employee is an appointive or elective state officer or employee in the service of the state of Texas, including an employee of an institution of higher education, as defined in the Act, Chapter 1551, *and Texas Insurance Code.*

Participant is an Employee, Retiree, or a Dependent, as defined in the Act, and surviving Dependents of deceased Employees and Retirees, or other persons eligible for coverage as provided under the Act while eligible for coverage and enrolled under the Plan. References to "You" and "Your" throughout this Evidence of Coverage are references to a Participant.

Participating General Dentist and Participating Specialty Dentist (hereinafter referred to as "Participating Dentist") are those licensed dentists selected and contracted with the Plan as independent contractors to provide Covered Dental Care Services to Participants. Participating General Dentists may include dentists that are contractually arranged to provide Dental Care Services to Participants at an onsite clinic.

Primary Care Dentist (PCD) is the Participating General Dentist within Our DHMO network whom you have selected to handle your dental care. Participating Care Dentists may include dentists that are contractually arranged to provide Dental Care Services to Participants at an onsite clinic.

Retiree (also known as annuitant) is an Employee who has retired as defined in the Act and, for purposes of Benefits under this Plan.

Service Area means the entire state of Texas.

Treatment Plan is that individual proposal by the Participating Dentist outlining the recommended course of Participant's Covered Dental Care Services. The Participant may request a written copy.

Usual Charges are those fees that are customarily charged for Covered Dental Care Services by the Participating Dentist. We do not determine said charges.

Year means the period of time which begins on any January 1st and ends on the following December 31st. When you first become covered by the Plan, the first Year begins for you on your effective date and ends on the following December 31st.

You or **Your** means the Participant.

We, **Us**, or **Our** means CompBenefits, a Humana company.

SPECIAL COMMUNICATION NEEDS

If You have special communication needs

We want the plan to be convenient for all Participants, particularly those with special needs. That is why We offer many materials in Spanish, English or other. If You are not comfortable speaking in English, You can still call Customer Care at (855) 756-6580. We have a number of bilingual Customer Care Representatives. If You have a disability affecting Your ability to communicate or read, this Evidence of Coverage is also available on audiocassette, in large type, Braille, and through the use of an interpreter.

Si usted necesita asistencia especial para comunicarse

Queremos que el plan sea conveniente para todos nuestros miembros, en especial aquellos quienes tengan requerimientos especiales. Con este fin ofrecemos muchos materiales impresos en espanol e ingles. Si no se siente comodo comunicandose en ingles, puede llamar sin embargo a Servicios Para Miembros al (855) 756-6580. Tenemos a varios representantes bilingues. Si tiene alguna invalidez que afecte sus posibilidades de comunicarse o de leer, este manual es disponible en forma de audio cassette, en letra mayuscula, en letra para desprovistos de vista y tambien por medio de un interprete.

INTRODUCING THE DHMO DENTAL PLAN

Welcome to the DHMO Plan (“Plan”), a single service dental health maintenance organization (“DHMO”). We are pleased that You have selected Our coverage for Your dental needs. This Evidence of Coverage (“EOC”) contains a description of Covered Dental Care Benefits as well as Copayments, limitations and exclusions. There is a helpful glossary located in the appendix of this EOC that gives definitions of dental terminology found in this EOC. You have a responsibility to know what services are covered under Your dental plan. **Please read this EOC carefully**. If You have questions about what Your dental plan covers, please refer to Your EOC and Schedule of Benefits or call Customer Care at (855) 756-6580.

HOW THE DHMO PLAN WORKS

Your dental plan is designed to help You and Your family obtain comprehensive dental care by offering inexpensive preventive care and reduced rates for many other dental treatments. You will only pay a Copayment for Covered Dental Care services or treatments You receive at the time services are performed, unless You make other payment arrangements with Your Participating Dentist. You should ask Your Participating Dentist for a benefit determination and cost estimate before You receive any dental treatment.

GETTING STARTED

Selecting Your Dentist

First, You must select a Participating General Dentist from a list of dentists participating in the Plan network as Your primary care dentist (“PCD”). A directory of all the Participating Dentists will be provided for You upon request. The directory is sorted by city, and lists all the dentists in the facility, the address, telephone number, and if the dentist is accepting new patients. Provider directories are updated frequently and available on Our website, however, paper copies can be requested from Customer Care. If You need assistance finding a PCD, call Customer Care at (855) 756-6580 or use the Find Care function on the HumanaDental DHMO tab of www.ERSdentalplans.com. Once You have identified a PCD, You can make that selection through the MyHumana portal or You may contact Our Customer Care department with Your selection.

You may select a different PCD at any time. All requests for dentist changes received by the 15th of the month will become effective on the 1st of the following month. Requesting a change of dentist more than twice in a 30-day period is considered excessive and may not be honored.

On rare occasions it may be necessary for You to select another dentist. A change may be necessary in the following situations:

- if Your selected dentist decides to no longer participate in the Plan network;
- if the dentist is unable to effectively provide the care You need;
- if efforts to establish a satisfactory relationship between You and the dentist have failed; or
- if You refuse treatment from the dentist that he or she feels is necessary.

If a change is needed, You will be asked to select another dentist from the directory. We strive to provide written notification if Your provider leaves the plan and will send You a letter indicating the change to assist in Your selection of another dentist.

In the event the Covered Dental Care Services You need are not available through Participating Dentists, the Plan, upon the request of a Participating Dentist, within the time appropriate to the circumstances relating to the delivery of the Covered Dental Care Services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-Participating Dentist and shall reimburse the non-Participating Dentist at the usual and customary or an agreed rate less the Copayment amount. You are responsible for paying the Copayment amount to the non-Participating Dentist. Contact Us if You receive a bill for covered services from any physician or provider, including a facility-based physician or other health care practitioner. For purposes of determining whether Covered Dental Care Services are available through Participating Dentists, the Plan shall offer its entire network, rather than limited provider networks within the Plan's delivery network. The Plan shall not require You to change Your PCD to receive Covered Dental Care Services that are not available within the limited provider network. The Plan will provide for a review by a specialist of the same or similar specialty as the type of dentist or provider to whom a referral is requested before the Plan authorizes a referral to a non-Participating Dentist.

Making an Appointment

When You need dental care, simply call Your PCD's office to make an appointment. When You call, make sure You have Your ID card handy, in case You are asked questions regarding Your dental plan. All non-emergency Covered Dental Care Services shall be on a prior appointment basis during the normal office hours of the Participating Dentist. In order to receive Benefits, You must first make an appointment with your PCD, and the request for an appointment must be made after the Effective Date. When making an appointment, You should inform the Dental Facility that You are a Plan Participant. You may request an emergency appointment (treatment of accidental, painful, or urgent conditions) within 24 hours of calling the Dental Facility, subject to the appropriate Copayment. For dental emergencies, please refer to the "Emergency Care" section below.

Broken Appointments

The time that the dentist sets aside for Your appointment is very valuable. Broken appointments are more than just an inconvenience or a discourtesy, they greatly add to the expense of the program as a delay in treatment may require more complex and costlier procedures. Also, the time the dentist scheduled for You could have been used for other patients for needed dental care. Therefore, should You break an appointment without at least 24 hours notice, and Your Participating General Dentist charges a fee for broken appointments, the fee is not covered by Us, and is Your responsibility. Any fees, if applicable, are determined by the dentist.

Specialty Care

You may be referred by Your PCD or you may self-refer to a Participating Specialty Dentist (i.e. endodontist, orthodontist, oral surgeon, periodontist, prosthodontist, or pediatric dentist). Please refer to Your Schedule of Benefits for payment and benefit information applicable to Participating Specialty Dentists.

Second Opinions

Both You and Your dentist decide on Your course of treatment. If You are not satisfied with Your Participating Dentist's treatment plan, We encourage You to get a second opinion from another Participating Dentist. The second consultation is subject to any applicable Copayments. Please refer to Your Schedule of Benefits for the exact amount.

Whether You need routine, preventive care or just have a dental question, You should call Your selected PCD first.

Pre-Treatment Estimate

If the cost of Your services are expected to exceed $200, the Plan recommends that You ask the dentist to submit a Treatment Plan for a Pre-Treatment Estimate to our Claims Department. The Claims Department will process the Treatment Plan and send You a copy of the estimate of benefits for planned services. The estimate will remain valid for up to 180 days and is based upon Benefits available at the time of processing. It may change if other claims are submitted prior to completion of treatment. This gives You the opportunity to know the amount of Benefits allowable before any fees are incurred.

Alternate Treatment

The treatment of a dental condition is often discretionary, that is there is more than one way to treat a dental problem. For example, either a crown or a filling could be used to restore a tooth. Another example is in some cases a fixed partial denture or a removable partial denture may be used. If more than one type of service can be used to treat a dental condition, the Plan has the right to base Benefits on the least expensive service. If You and Your dentist decide that You want the alternative treatment, You will be responsible for charges exceeding the least expensive treatment cost.

EMERGENCY CARE

The Plan covers dental emergencies 24 hours a day, seven days a week, no matter where You are. If You have a dental emergency, You are covered for palliative (emergency) treatment. Palliative treatment involves only those things necessary to control unexpected pain or more than usual bleeding, prevent complications related to an infection, or prevent the loss of a tooth from a traumatic injury. Emergency dental service is intended to relieve pain caused by an acute condition until Your PCD can see You. **Your emergency care benefit does not include procedures that may be required, but are not necessary for the relief of pain.** For example, root canals and crowns may be necessary treatments but are not covered under emergency care benefits.

What is considered an emergency dental service?

Emergency dental services are limited to procedures administered in a dentist's office, dental clinic, or other comparable facility; to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

What should you do in an emergency?

You can receive palliative (emergency) treatment from any licensed dentist. In the event You receive palliative (emergency) treatment from a non-Participating Dentist, You will be reimbursed for the cost of the emergency care minus any applicable Copayments. In order to be reimbursed for the services, You must have an itemized statement and receipt showing the services paid in full from the treating dentist. We must be notified of such treatment within 90 days of its receipt, or as soon as reasonably possible. Contact Us if You receive a bill for covered services from any physician or provider, including a facility-based physician or other health care practitioner.

CONTINUITY OF CARE

You may be eligible to request continuity of care as of the date the following events occur:

- The dentist terminates as a network provider;
- The terms of a dentist’s participation in the network changes in a manner that terminates a benefit for a service You are receiving as a continuing care patient; or
- The group plan terminates.

If You request continuity of care, We will apply the network provider copayment to covered dental services related to Your treatment as a continuing care patient.

Continuity of care will end upon the earlier of:

- 90 days from the date we notify You the dentist is no longer a network provider;
- 90 days from the date we notify You the terms of a dentist’s participation in the network changes in a manner that terminates a benefit for a service You are receiving as a continuing care patient;
- 90 days from the date We notify You the group plan terminates; or
- The date You are no longer a continuing care patient.

Continuity of care is not available if:

- The dentist’s participation in Our network is terminated due to medical competence or professional behavior.
- Your coverage terminates; however, the group plan remains in effect.

All terms and provisions of the group plan are applicable to this "Continuity of care" provision.

IF YOU HAVE A COMPLAINT

We are committed to offering outstanding service to plan Participants. If You have a concern or complaint about Your dental care or coverage, the way We manage it, or a decision We have made, We want to know. Our goal is to acknowledge and resolve complaints in a timely manner. We monitor complaints and use this feedback from Participants to improve Our performance.

Complaints

Our Customer Care Department is available by phone Monday through Friday, 8 a.m. to 7 p.m. Central Time to assist Participants in addressing any dissatisfaction with their dental plan benefits and/or participating dental office. You can call Customer Care at (855) 756-6580 or submit a Complaint in writing. Written Complaints should be mailed to:

Attn: Humana Grievance and Appeal Department
Humana/CompBenefits
P.O. Box 14163
Lexington, KY 40512-4163

If You submit a written Complaint, please include Your concern, specific details, dates, and Your name and contact information. Should You have any question about submitting a written Complaint, call Customer Care at (855) 756-6580. Complaints must be submitted to Us within one year of the occurrence of events upon which the Complaint is based, or as soon as reasonably possible if it was not reasonably possible to submit Your Complaint within such time. Your Complaint will be acknowledged in writing within five business days of receipt, and if the Complaint was made orally, it will be accompanied by a one-page Complaint form that prominently and clearly states that the form must be returned to Us for prompt resolution of the Complaint. Written Complaints will be researched and resolved and a response letter explaining the Plan's resolution of the Complaint will be sent to You within 30 days from the date of receipt. The letter will include Our resolution of the Complaint, the specific dental and contractual reasons for the resolution, the specialization of any dentist or other provider consulted, and a complete description of the process of appeal including the deadlines for the appeals process and the deadlines for the final decision on the appeal.

In the event the Complaint concerns a dental emergency, We shall investigate and resolve a Complaint concerning a dental emergency in accordance with the dental immediacy of the case and not later than one business day after We receive the Complaint.

Appeal of Complaint Resolution

If the Complaint is not resolved to Your satisfaction, You have the right within 60 days of the initial determination to Appeal the resolution of Your Complaint and appear in person before a Complaint Appeal panel at the site where You normally receive dental services or at an agreed upon location, or You may address a written Appeal directly to the panel at:

Attn: Humana Grievance and Appeal Department
P.O. Box 14163
Lexington, KY 40512-4163
(855) 756-6580

We will send You an acknowledgment letter within five business days of the receipt of Your Appeal request. You will be contacted to make arrangements for a meeting or to submit Your written Appeal. The Plan shall complete the appeals process not later than the 30th calendar day after the date the written request for appeal is received. Not later than the fifth (5th) business day before the date the Appeal panel is scheduled to meet, unless You agree otherwise, We shall provide You or Your designated representative: 1) any documentation to be presented to the Appeal panel by Plan staff; 2) the specialization of any dentists or providers consulted during the investigation; and 3) the name and affiliation of each Plan representative on the Appeal panel. The Appeal panel consists of an equal number of Plan staff members, dentists or other providers, and enrollees who were not previously involved in the disputed decision. The dentists or other providers on the Appeal panel must have experience in the area of care that is in dispute and be independent of any dentist or provider who made any previous

determination. If specialty care is in dispute, the Appeal panel will include a person who is a specialist in the field of care to which the appeal relates. They will consider all information presented and give a decision on the Appeal. Once the Appeal panel reaches a decision, You will receive a letter with specific clinical and contractual criteria used to reach the decision. Should You disagree with the decision of the appeal panel, or at any time You are dissatisfied, You have the right to contact the **Texas Department of Insurance** at the following:

Consumer Protection, MC: CO-CP
Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030
(800) 252-3439
ConsumerProtection@tdi.texas.gov

The Plan is prohibited from retaliating against You or the Contractholder for filing a complaint against the Plan or for appealing a Plan decision. The Plan is also prohibited from retaliating against a dentist because the dentist has on behalf of a Participant, filed a complaint against the Plan or appealed a Plan decision.

In the event the Appeal involves ongoing emergency dental treatment, the investigation and resolution of an Appeal of a complaint relating to an ongoing emergency shall be concluded in accordance with the dental immediacy of the case, and not later than one business day after Your request for an Appeal is received. Because of the ongoing emergency, We shall provide, instead of an Appeal panel, a review by a dentist who: 1) has not previously reviewed the case; and 2) is of the same or a similar specialty as the dentist or provider who would typically managed the dental condition, procedure, or treatment under consideration for review in the appeal. The dentist or provider reviewing the appeal may interview You or Your designated representative and shall decide the Appeal. The dentist or provider may deliver initial notice of the decision on the Appeal orally if the dentist or provider subsequently provides written notice of the decision not later than the third day after the date of the decision.

ELIGIBILITY AND COVERAGE

ERS is responsible for establishing eligibility and reporting enrollment. For more information about eligibility and enrollment please contact Your Benefits Coordinator or go to www.ERS.Texas.gov.

CANCELLATION AND NON-RENEWAL

Plan may cancel a Participant's coverage with the approval of ERS for the following reasons:

- You or Your Dependents cease to be eligible under the terms of the Program as determined by ERS.
- Immediately, subject to continuation of coverage provision, if applicable, for failure to meet eligibility requirements other than the requirement that the Participant reside, live, or work in the Service Area; and
- After not less than 15 days written notice, in the case of fraud or intentional misrepresentation of a material fact, except as described in Incontestability section of this EOC;
- After not less than 15 days written notice, in the case of fraud in the use of services or facilities;
- After not less than 30 days written notice, where the Participant does not reside, live or work in the Service Area of the HMO or area for which the HMO is authorized to do business, but only if the HMO terminates coverage uniformly without regard to any health status-related factor of enrollees, except that an HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the Service Area.

Cancellation of Your coverage by the Plan is without prejudice. Participating Dentists shall complete all dental procedures You may be undergoing. Your dentist will treat You until the specific treatment or procedure has been completed or for 90 days, whichever is less.

CONTINUATION OF COVERAGE

If Your coverage under the Plan is terminated for any reason, except involuntary termination for cause, and You were continuously covered under this Plan for 3 consecutive months prior to losing coverage, You can transfer Your dental benefits to an individual plan or You can continue Your group coverage subject to the eligibility provisions below:

1. Continuation of group coverage must be requested in writing within 60 days following the later of: (a) the date the group coverage would otherwise terminate; or (b) the date the Participant is given notice of the right of continuation by the Contractholder.

2. A Participant electing continuation must pay to the Contractholder on a monthly basis, in advance, the amount of contribution required by the Contractholder, plus two percent of the group rate for the coverage being continued under the group Plan, on the due date of each payment.

3. The Participant must make the payment no later than the 45th day after the date of the initial election for coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for coverage, the payment of any other premium shall be considered timely if made on or before the 30th day after the date on which the payment is due.

4. Continuation may not terminate until the earliest of: (a) the date the maximum continuation period provided by law would end, which is: (i) for any Participant not eligible for continuation coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), nine (9) months after the date the Participant elects to continue the group coverage; or (ii) for any Participant eligible for continuation coverage under COBRA, six (6) additional moths following any period of continuation coverage provided under COBRA; (b) the date on which failure to make timely payments would terminate coverage; (c) the date the group coverage terminates in its entirety; (d) the date on which the Participant is covered for similar services and benefits by another dental insurance policy or dental subscriber contract or dental practice or other prepayment plan. If a Participant loses coverage due to a change in marital status, that Participant shall be issued coverage which the Plan is then issuing which most nearly approximates the coverage of the Plan which was in effect prior to the change in marital status. The new coverage will be issued without evidence of insurability and will have the same effective date as the Plan under which coverage was afforded prior to the change in marital status. If a Participant loses coverage due to a change in marital status, that Participant shall be issued coverage which the Plan is then issuing which most nearly approximates the coverage of the Plan which was in effect prior to the change in marital status. The new coverage will be issued without evidence of insurability and will have the same effective date as the Plan under which coverage was afforded prior to the change in marital status.

GENERAL PROVISIONS

Entire Contract
The Contractual Agreement, this EOC, applications, if any, and any attachments constitute the entire contract between the parties and that, to be valid, any change in the form must be approved by an officer of the HMO and attached to the affected form and no agent has the authority to change the form or waive any of the provisions.

Any direct conflict between the group Contractual Agreement and this EOC will be resolved according to the terms most favorable to the Participant.

Exclusions and Limitations

Plan does not provide coverage for the following:

1. No service of any dentist other than a Participating General Dentist or Participating Specialty Dentist will be covered by Plan, except for emergency care as described in the Emergency Care section. This does not include services performed by non-Participating Dentists approved by the Plan.

2. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.

3. Any dental treatment started prior to the Participant's effective date for eligibility of benefits, other than covered orthodontic treatment (as detailed below). Covered orthodontic procedures started before the Participant is covered under this Plan are limited as follows:

    - Upon request of a newly covered Participant, We will provide Benefits for the completion of Covered Dental Care Services begun prior to the time his or her coverage became effective. We will not provide coverage for incomplete services that are not otherwise Benefits under the terms and conditions of the Evidence of Coverage and Schedule of Benefits. Participants may request completion of treatment in progress by calling Customer Care at (855) 756-6580 during normal business hours, or by sending a written request to Us.

    - If the dentist providing the orthodontic services is not a Participating Dentist, we can make reasonable and appropriate arrangements for completion of such treatment by a Participating Dentist.

    - Orthodontic treatment in progress is limited to new Participants who, at the time of their original effective date, are in active treatment as long as they continue to be covered under this Plan. Active treatment means bands have been placed. If applicable, Participants are responsible for all Copayments and fees subject to the provisions of their prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

    - The cost to a Participant receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the orthodontist's submitted fee for the treatment plan. The orthodontist will prorate the amount for the number of months remaining to complete treatment. The Participant makes payment directly to the orthodontist as arranged.

4. Any services that are not appropriate or customarily performed for the given condition, do not have uniform professional endorsement, do not have a favorable prognosis, or are experimental or investigational.

5. Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialty Dentist or which in the opinion of the Participating General Dentist or Participating Specialty Dentist would endanger the health of the Participant.

6. Any service or procedure which the Participating General Dentist or Participating Specialty Dentist is unable to perform because of the general health or physical limitations of the Participant.

7. Procedures, appliances or restorations to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ); or replacement of lost, missing or stolen appliances.

8. Services performed primarily for cosmetic purposes, unless otherwise listed as covered cosmetic services on Your Schedule of Benefits.

9. Services provided by a Participating Pediatric Dentist are limited to children through age 18.

10. Removal of asymptomatic third molars is not covered unless pathology (disease) exists. Examples of symptomatic conditions include decay, cysts, unmanageable periodontal disease, infection, and resorption of adjacent tooth.

11. Frequency and/or age limitations may apply. See your Schedule of Benefits and Copayments for details.

12. Services for injuries and conditions which are covered under Workers' Compensation or Employers Liability laws.

13. Crowns, inlays, onlays, or veneers for the purpose of:

    - Altering vertical dimension of teeth;
    - Restoration or maintenance of occlusion;
    - Splinting teeth, including multiple abutments; or
    - Replacing tooth structure lost as a result of wear (abrasion, attrition, erosion or abfraction).

The Plan does not exclude from coverage, Covered Dental Care Services for a Participant who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by a Participant's physician or by the dentist providing the dental care.

Incontestability

This Evidence of Coverage may only be contested because of fraud or intentional misrepresentation of material fact in a written application.

All statements made by a Participant on the enrollment application shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of the Participant's knowledge and belief. A statement may not be used in a contest to void, cancel, or non-renew an enrollee's coverage or reduce benefits unless it is in a written enrollment application signed by You, and a signed copy of the enrollment application is or has been furnished to You or Your personal representative.

Conformity with Texas Law

If this EOC contains any provision or part of a provision not in conformity with Texas Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges) or other applicable laws, the remaining provisions and parts of provisions that can be given effect without

the invalid provision or part of a provision are not rendered invalid but must be construed and applied as if they were in full compliance with Insurance Code Chapter 1271 and other applicable laws.

Notice of Independent Contractor Relationship

The Plan assumes responsibility of fulfilling the terms of this EOC. Participating Dentists are independent contractors. The Plan cannot be held responsible for any damages incurred as a result of tort, negligence, breach of contract, or malpractice by a Participating Dentist, or for any damages which result from any defective or dangerous condition in or about any Dental Facility.

Claims

The Plan shall, not later than the 45th day after receipt of notice of a clean paper claim, or not later than the 30th day after receipt of a clean electronic claim: (1) pay the claim in accordance with any contracts We may have with the provider; (2) pay any portion of claim that is not in dispute and notify the provider in writing of the reason for the disputed amount; or (3) notify the provider in writing why the claims will not be paid.

If We need additional information from the claimant or provider to determine payment, We will request in writing that the claimant or provider submit clarification of the claim or additional documentation, not later than the 15th day after the date We receive notice of claim.

We will notify a claimant in writing of the acceptance or rejection of the claim not later than the 15th business day after the date We receive all items, statements, and forms, in order to secure final proof of loss. Once We notify a claimant that We will pay a claim or part of a claim, We shall pay the claim not later than the fifth business day after the date notice is made.

Dental Records

Dental records concerning services rendered to Participant shall remain the property of the Participating Dentist. Participant may obtain copies of their dental records for a reasonable fee directly payable to the Participating Dentist. Participant agrees that his/her dental records may be reviewed by the Plan to fulfill its obligations under the contract. The Plan agrees to honor confidentiality of said data.

GLOSSARY OF DENTAL TERMINOLOGY

Abscess – a localized infection due to a collection of pus in the bone or soft tissue caused by severe decay, trauma, or gum disease.

Alveolar - referring to a bone to which a tooth is attached.

Alveoplasty - surgical procedure for recontouring alveolar structures, usually in preparation for a prosthesis.

Amalgam -a silver/mercury mixture which is used for fillings.

Anterior - refers to the teeth in the forward part of the mouth - incisors and canines.

Apicoectomy - amputation of the root of the tooth.

Bitewing -an x-ray between the adjoining surfaces of adjacent teeth.

Bridge - a prosthetic replacement of one or more missing teeth on a framework that cannot be removed by the patient.

Cavity - lesion or hole in the tooth caused by decay.

Cement/Recement/Recementation – the application or re-application of a special type of glue to hold a crown in place or to protect the tooth's nerve.

Crown - part of the tooth that is covered with enamel; also a cover for decayed or damaged tooth made of porcelain and/or metal is called by the same name.

Curettage - scraping or cleaning the walls of a cavity or gingival pocket.

Debridement - removal of foreign matter.

Denture - an artificial substitute for natural teeth and adjacent tissues.

Denture base - that part of a denture that makes contact with soft tissue and retains the artificial teeth.

Diagnostic cast - plaster or stone model of teeth and adjoining tissues; also referred to as Study Model.

Endodontist - a dentist who specializes in root canals and treatment of diseases or injuries of the pulp and the area surrounding the root of the tooth

Extraction - removal of a tooth.

Filling - a lay term used for the restoring of lost tooth structure by using materials such as metal, plastic or cement.

Gingiva - the gums.

Gingivectomy - the excision or removal of gingiva.

Gingivoplasty - surgical procedure to reshape gingiva to create a normal, functional form.

Graft - a piece of tissue or alloplastic material placed in contact with tissue to repair a defect or supplement a deficiency.

Immediate denture - prosthesis constructed for placement immediately after removal of remaining natural teeth.

Impacted tooth - usually associated with a wisdom tooth, it is a tooth that is under the gum tissue.

Inlay - a dental restoration made outside the mouth to correspond to the prepared tooth, which is then cemented to the tooth.

Intraoral - inside the mouth.

Labial - pertaining to or around the lip.

Malocclusion - improper alignment of biting or chewing surfaces of upper and lower teeth.

Mandible (mandibular – adj.) - lower jaw.

Maxilla (maxillary – adj.) - upper jaw.

Occlusion - any contact between biting or chewing surfaces of upper and lower teeth.

Oral - pertaining to the mouth.

Oral evaluation - a thorough evaluation the state of health of the mouth, teeth and gums.

Oral surgeon - a dentist who specializes in surgical and adjunctive treatment of diseases, injuries, deformities, defects and esthetic aspects of the mouth.

Orthodontics - a specialized branch of dentistry that corrects malocclusions and restores teeth to proper alignment and function.

Osseous - bony.

Palliative - action that relieves pain but is not curative (for example, root canals and crowns may be necessary treatments but are not covered under emergency care benefits.)

Panoramic - a full mouth x-ray (180 degree view) of the teeth, upper and lower jaws on one film.

Partial denture - usually refers to the prosthetic device that replaces the missing teeth on a framework that can be removed by the patient.

Pediatric dentist - a dentist who specializes in the treatment of children from birth through adolescence.

Periapical - the area surrounding the end of the tooth root.

Periodontist - a dentist who specializes in the treatment of diseases of the gums.

Permanent teeth - the 32 adult teeth that replace the primary or baby teeth. Also known as secondary teeth.

Pontic - the term used for the artificial tooth on a bridge.

Primary teeth - the first set of teeth; also known as deciduous teeth or baby teeth.

Prophylaxis - cleaning and polishing of the teeth to remove coronal plaque, calculus and stains.

Prosthodontist - a specialty dentist whose practice is limited to the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.

Pulp - the soft inner structure of the tooth, consisting of blood vessels and nerve tissue.

Pulp cavity - the space within a tooth that contains the pulp.

Pulpotomy - the removal of the coronal portion of the pulp.

Quadrant - one of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth; usually includes five or more teeth.

Reconstructive surgery for craniofacial abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Reline - process of resurfacing the tissue side of a denture with a new base material.

Root canal therapy - treatment of the pulp cavity to eliminate periapical disease and to promote healing and repair of periapical tissues.

Root planing - a procedure designed to remove microbial flora, bacterial toxins on the root surface or in the pocket, calculus and diseased cementum or dentin.

Scaling - removal of plaque, calculus and stains from teeth.

Sealant - a material which is bonded to a tooth to prevent decay.

Space maintainer - a device used to hold or maintain the space previously held by an extracted tooth.

Teledentistry - A dental service that is delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

Veneer - a layer of tooth colored material attached to the surface by fusion, cementation, or mechanical retention.

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn't pick the doctor, and for ambulance services.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling (800) 252-3439.

List of doctors

You can get a directory of health care providers that are in your plan's network.

You can get the directory online by using the Find Care function on the HumanaDental DHMO tab of www.ERSdentalplans.com.or by calling (855) 756-6580.

If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for health care

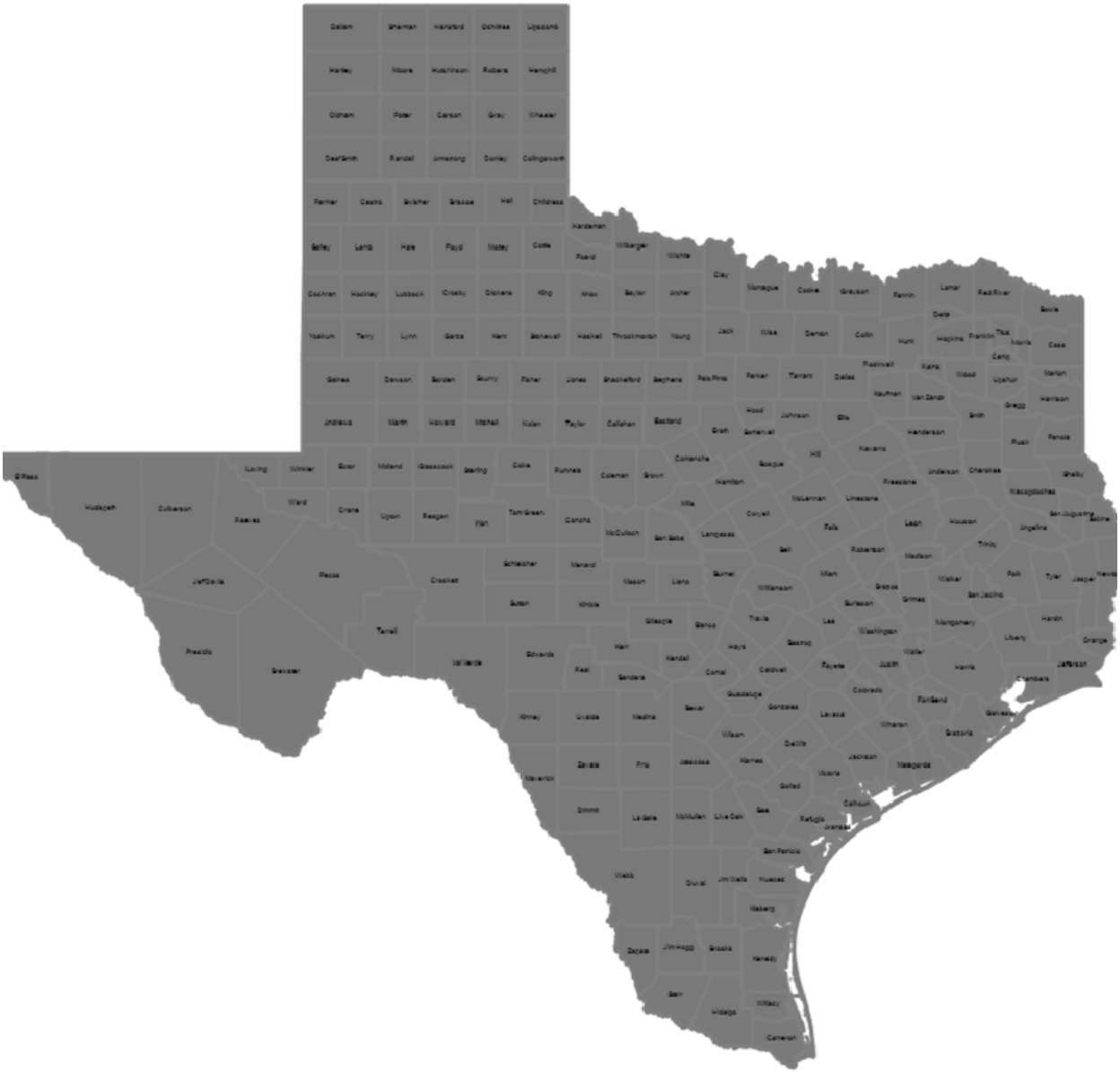
If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at tdi.texas.gov.

Service Area

The Service Area for this plan is the entire state of Texas. Please note that PCD locations may change from time to time. If you need assistance finding a PCD, call Customer Care at (855) 756-6580 or use the Find Care function on the HumanaDental DHMO tab of www.ERSdentalplans.com.

The following map shows the Service Area covered by this Evidence of Coverage:



HumanaDental DHMO for ERS

Humana

ERS® Employees Retirement System of Texas

CompBenefits

Schedule of Benefits and Subscriber Copayments

Office visit Copayment **$0**

Copayment amounts for listed procedures are applicable at the Participating General Dentist.

If You should need to see a specialist (i.e. endodontist, oral surgeon, periodontist, pediatric dentist), upon identification of yourself as a Participant, You will receive a 25% reduction from the Participating Specialist's usual fee for Covered Dental Care Services performed.

Diagnostic Services

ADACode	Procedure	Patient Pays
D0120	Periodic oral evaluation - established patient - *limited to two per year, or more frequently if medically necessary*	$0
D0140	Limited oral evaluation - problem focused	$22
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral - comprehensive series of radiographic images - *limited to one series of D0210 or D0330 every two years, or more frequently if medically necessary*	$0
D0220	Intraoral - periapical first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	$0
D0270	Bitewing - single radiographic image	$0
D0272	Bitewings - two radiographic images	$0
D0273	Bitewings - three radiographic images	$0
D0274	Bitewings - four radiographic images - *limited to two series per year*	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0330	Panoramic radiographic image - *limited to one series of D0210 or D0330 every two years, or more frequently if medically necessary*	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
D0396	3D printing of a 3D dental surface scan	$0
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0461	Testing for cracked tooth	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report – *available only when performed in conjunction with a covered biopsy*	$0

D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	$0
D0475	Decalcification procedure	$0
D0476	Special stains for microorganisms	$0
D0477	Special stains, not for microorganisms	$0
D0478	Immunohistochemical stains	$0
D0479	Tissue in-situ hybridization, including interpretation	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	$0
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	$42
D0502	Other oral pathology procedures, by report	$0
D0701	Panoramic radiographic image - image capture only	$0
D0702	2-D cephalometric radiographic image – image capture only	$0
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	$0
D0705	Extra-oral posterior dental radiographic image - image capture only	$0
D0706	Intraoral - occlusal radiographic image - image capture only	$0
D0707	Intraoral - periapical radiographic image - image capture only	$0
D0708	Intraoral - bitewing radiographic image - image capture only	$0
D0709	Intraoral - complete series of radiographic images - image capture only	$0
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$0

Preventive Services

ADACode	Procedure	Patient Pays
D1110	Prophylaxis - adult - *limited to two D1110, D1120 or D4346 per year, or more frequently if medically necessary*	$12
D1120	Prophylaxis - child - *limited to two D1110, D1120 or D4346 per year, or more frequently if medically necessary*	$12
D1206	Topical application of fluoride varnish - *limited to two D1206 or D1208 per year, or more frequently if medically necessary*	$0
D1208	Topical application of fluoride - excluding varnish -*limited to two D1206 or D1208 per year, or more frequently if medically necessary*	$0
D1310	Nutrition counseling for the control of dental disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$10
D1510	Space maintainer - fixed unilateral - per quadrant	$90
D1516	Space maintainer - fixed bilateral, maxillary	$90
D1517	Space maintainer - fixed bilateral, mandibular	$90
D1520	Space maintainer - removable - unilateral - per quadrant	$90
D1526	Space maintainer - removable - bilateral, maxillary	$90
D1527	Space maintainer - removable - bilateral, mandibular	$90
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$10
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$10
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$10
D1556	Removal of fixed unilateral space maintainer - per quadrant	$0
D1557	Removal of fixed bilateral space maintainer - maxillary	$0
D1558	Removal of fixed bilateral space maintainer - mandibular	$0
D1575	Distal shoe space maintainer – fixed unilateral - per quadrant	$140

Restorative Services

ADACode	Procedure	Patient Pays
D2140	Amalgam - one surface, primary or permanent	$22

D2150	Amalgam - two surfaces, primary or permanent	$27
D2160	Amalgam - three surfaces, primary or permanent	$32
D2161	Amalgam - four or more surfaces, primary or permanent	$37
D2330	Resin-based composite - one surface, anterior	$27
D2331	Resin-based composite - two surfaces, anterior	$32
D2332	Resin-based composite - three surfaces, anterior	$37
D2335	Resin-based composite - four or more surfaces, anterior	$52
D2390	Resin-based composite - crown, anterior	$40
D2391	Resin-based composite - one surface, posterior	$47
D2392	Resin-based composite - two surfaces, posterior	$57
D2393	Resin-based composite - three surfaces, posterior	$67
D2394	Resin-based composite - four or more surfaces, posterior	$74
D2410	Gold foil - one surface	$60
D2420	Gold foil - two surfaces	$140
D2430	Gold foil - three surfaces	$180

Major Restorative

- When there are more than six crowns in the same treatment plan, a Participant may be charged an additional $135.00 per crown, beyond the sixth unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be five or more years old.
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- Temporary metal crowns (with permanent) included at no cost.

ADACode	Procedure	Patient Pays
D2510	Inlay - metallic - one surface	$140
D2520	Inlay - metallic - two surfaces	$170
D2530	Inlay - metallic - three or more surfaces	$200
D2542	Onlay - metallic - two surfaces	$250
D2543	Onlay - metallic - three surfaces	$260
D2544	Onlay - metallic - four or more surfaces	$270
D2610	Inlay - porcelain/ceramic, one surface	$247
D2620	Inlay - porcelain/ceramic, two surfaces	$297
D2630	Inlay - porcelain/ceramic, three or more surfaces	$297
D2642	Onlay - porcelain/ceramic, two surfaces	$317
D2643	Onlay - porcelain/ceramic, three surfaces	$317
D2644	Onlay - porcelain/ceramic, four or more surfaces	$327
D2650	Inlay - resin based composite, one surface	$172
D2651	Inlay - resin based composite, two surfaces	$182
D2652	Inlay - resin based composite, three or more surfaces	$212
D2662	Onlay - resin based composite, two surfaces	$212
D2663	Onlay - resin based composite, three surfaces	$222
D2664	Onlay - resin based composite, four or more surfaces	$237
D2710	Crown - resin-based composite (indirect)	$318
D2712	Crown -3/4 resin-based composite (indirect)	$318
D2720	Crown - resin with high noble metal	$368
D2721	Crown - resin with predominantly base metal	$260
D2722	Crown - resin with noble metal	$299
D2740	Crown - porcelain/ceramic	$410
D2750	Crown - porcelain fused to high noble metal	$410
D2751	Crown - porcelain fused to predominantly base metal	$360
D2752	Crown - porcelain fused to noble metal	$399
D2753	Crown - porcelain fused to titanium and titanium alloys	$410
D2780	Crown - 3/4 cast high noble metal	$399
D2781	Crown - 3/4 cast predominantly base metal	$350
D2782	Crown - 3/4 cast noble metal	$389
D2783	Crown - 3/4 porcelain/ceramic	$350
D2790	Crown - full cast high noble metal	$410
D2791	Crown - full cast predominantly base metal	$360

D2792	Crown - full cast noble metal	$399
D2794	Crown - titanium and titanium alloy	$410
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration – *(by original dentist)*	$0
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration - *(by new dentist)*	$5
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$5
D2920	Re-cement or re-bond crown *(by original dentist)*	$0
D2920	Re-cement or re-bond crown *(by new dentist)*	$5
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$55
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$55
D2930	Prefabricated stainless steel crown - primary tooth	$50
D2931	Prefabricated stainless steel crown - permanent tooth	$55
D2932	Prefabricated resin crown	$0
D2933	Prefabricated stainless steel crown with resin window	$65
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$65
D2940	Placement of interim direct restoration	$5
D2950	Core buildup, including any pins when required	$65
D2951	Pin retention - per tooth, in addition to restoration	$0
D2952	Post and core, in addition to crown, indirectly fabricated	$62
D2953	Each additional indirectly fabricated post - same tooth	$18
D2954	Prefabricated post and core in addition to crown	$58
D2956	Removal of an indirect restoration on a natural tooth	$0
D2957	Each additional prefabricated post - same tooth	$15
D2961	Labial veneer (resin laminate) - indirect	$297
D2962	Labial veneer (porcelain laminate) - indirect	$380
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$15
D2975	Coping	$148
D2976	Band stablization - per tooth - *limited to once in a lifetime per tooth*	$32
D2980	Crown repair necessitated by restorative material failure	$30
D2981	Inlay repair necessitated by restorative material failure	$30
D2982	Onlay repair necessitated by restorative material failure	$30
D2983	Veneer repair necessitated by restorative material failure	$30
D2990	Resin infiltration of incipient smooth surface lesions	$30
D2991	Application of hydroxyapatite regeneration medicament - per tooth – *limited to twice per tooth in a one-year period*	$30
D2999	Unspecified procedure, by report	$0

Endodontics

- *Culturing canal included at no cost.*

ADACode	Procedure	Patient Pays
D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$35
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$170
D3320	Endodontic therapy, premolar tooth (excluding final restorations)	$190
D3330	Endodontic therapy, molar tooth (excluding final restorations)	$250
D3351	Apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$0
D3352	Apexification/recalcification - interim medication replacement (includes any necessary radiographs)	$0
D3353	Apexification/recalcification - final visit (includes any necessary radiographs)	$0
D3410	Apicoectomy - anterior	$140
D3421	Apicoectomy - premolar (first root)	$140
D3425	Apicoectomy - molar (first root)	$170

D3426	Apicoectomy (each additional root)	$90
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$150
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$150
D3430	Retrograde filling - per root	$35
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$150
D3450	Root amputation - per root	$55
D3470	Intentional reimplantation (including necessary splinting)	$55
D3910	Surgical procedure to isolate tooth with rubber dam	$3
D3911	Intraorifice barrier	$0
D3920	Hemisection (including any root removal), not including root canal therapy	$66
D3921	Decoronation or submergence of an erupted tooth	$28
D3999	Unspecified endodontic procedure, by report	$0

Periodontics

- Periodontal regenerative procedures, D4263 and D4264 are limited to one per site (or per tooth, if applicable).
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.
- Participant pays a fee not to exceed $13.00 for periodontal probing.
- Home care instructions for periodontal management included at no cost.
- Post-therapeutic evaluation included at no cost.

ADACode	Procedure	Patient Pays
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$156
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$94
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$0
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$220
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$132
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$220
D4261	Osseous surgery (including elevation of a Full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$132
D4263	Bone replacement graft - retained natural tooth - first site in quadrant. *4263 and 4264 are limited to one per site.*	$150
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant *4263 and 4264 are limited to one per site.*	$150
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$150
D4322	Splint - intra-coronal; natural teeth or prosthetic crowns	$60
D4323	Splint - extra-coronal; natural teeth or prosthetic crowns	$60
D4341	Periodontal scaling and root planing, four xor more teeth; per quadrant *A maximum of four quadrants will be paid in any combination with D4342, per year*	$50
D4342	Periodontal scaling and root planning - one to three teeth, per quadrant *A maximum of four quadrants will be paid in any combination with D4341, per year*	$32
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *limited to two D1110, D1120 or D4346 per year, or more frequently if medically necessary*	$70
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *limited to one treatment in a one-year period*	$42
D4910	Periodontal maintenance	$37
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$0
D4999	Unspecified periodontal procedure, by report	$0

Prosthodontics (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. Participant must continue to be eligible, and the service must be provided at the Participating Dentist's facility where the denture was originally delivered.

- Replacement of a denture or a partial denture requires the existing denture to be more than five years old.

- If a Participant receives a duplicate complete denture (D5110 or D5120) within five years of placement, the Copayment for the duplicate denture is $260.00.

ADACode	Procedure	Patient Pays
D5110	Complete denture - maxillary	$490
D5120	Complete denture - mandibular	$490
D5130	Immediate denture - maxillary	$518
D5140	Immediate denture - mandibular	$518
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$503
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$503
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$578
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$578
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$503
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$503
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$578
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$578
D5225	Maxillary partial denture - flexible (Including retentive/clasping materials, rests and teeth)	$538
D5226	Mandibular partial denture - flexible (Including retentive/clasping materials, rests and teeth)	$538
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$503
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$503
D5410	Adjust complete denture – maxillary *(by original dentist)*	$0
D5410	Adjust complete denture – maxillary *(by new dentist)*	$10
D5411	Adjust complete denture – mandibular *(by original dentist)*	$0
D5411	Adjust complete denture – mandibular *(by new dentist)*	$10
D5421	Adjust partial denture – maxillary *(by original dentist)*	$0
D5421	Adjust partial denture – maxillary *(by new dentist)*	$10
D5422	Adjust partial denture – mandibular *(by original dentist)*	$0
D5422	Adjust partial denture – mandibular *(by new dentist)*	$10
D5511	Repair broken complete denture base, mandibular	$35
D5512	Repair broken complete denture base, maxillary	$35
D5520	Replace missing or broken teeth - complete denture - per tooth	$20
D5611	Repair resin partial denture base, mandibular	$78
D5612	Repair resin partial denture base, maxillary	$78
D5621	Repair cast partial framework, mandibular	$78
D5622	Repair cast partial framework, maxillary	$78
D5630	Repair or replace broken retentive clasping materials - per tooth	$78
D5640	Replace missing or broken teeth - partial denture - per tooth	$78
D5650	Add tooth to existing partial denture - per tooth	$78
D5660	Add clasp to existing partial denture - per tooth	$78

D5670	Replace all teeth and acrylic on cast metal framework - maxillary	$164
D5671	Replace all teeth and acrylic on cast metal framework - mandibular	$164
D5710	Rebase complete upper denture - *one per arch in any 12 consecutive month*s	$164
D5711	Rebase complete lower denture - *one per arch in any 12 consecutive month*s	$164
D5720	Rebase maxillary partial denture - *one per arch in any 12 consecutive month*s	$164
D5721	Rebase mandibular partial denture - *one per arch in any 12 consecutive month*s	$164
D5725	Rebase hybrid prosthesis - *one per arch in any 12 consecutive month*s	$164
D5730	Reline complete maxillary denture (direct) - *one per arch in any 12 consecutive month*s	$60
D5731	Reline complete mandibular denture (direct) - *one per arch in any 12 consecutive month*s	$60
D5740	Reline maxillary partial denture (direct) - *one per arch in any 12 consecutive month*s	$60
D5741	Reline mandibular partial denture (direct) - *one per arch in any 12 consecutive month*s	$60
D5750	Reline complete maxillary denture (indirect) - *one per arch in any 12 consecutive month*s	$75
D5751	Reline complete mandibular denture (indirect) - *one per arch in any 12 consecutive month*s	$75
D5760	Reline maxillary partial denture (indirect) - *one per arch in any 12 consecutive month*s	$75
D5761	Reline mandibular partial denture (indirect) - *one per arch in any 12 consecutive month*s	$75
D5765	Soft liner for complete or partial removable denture - indirect	$75
D5810	Interim complete denture (maxillary)	$60
D5811	Interim complete denture (mandibular)	$60
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth) - maxillary - *one per arch in any 12 consecutive month*s	$90
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth) - mandibular - *one per arch in any 12 consecutive month*s	$90
D5850	Tissue conditioning, maxillary *one per arch in any 12 consecutive month*s	$20
D5851	Tissue conditioning, mandibular *one per arch in any 12 consecutive month*s	$20
D5862	Precision attachment, by report	$150
D5899	Unspecified removable prosthodontic procedure, by report	$0

D5900-5999 Maxillofacial Prosthetics **Not Covered**

Implant Services

- When there are more than six crowns in the same treatment plan, a Participant may be charged an additional $135.00 per crown, beyond the sixth unit.

- Replacement of crowns, bridges and implant supported dentures requires the existing restoration to be more than five years old.

ADACode	Procedure	Patient Pays
D6010	Surgical placement of implant body: endosteal implant	$900
D6049	Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	$175
D6058	Abutment supported porcelain/ceramic crown	$461
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$461
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$412
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$451
D6062	Abutment supported cast metal crown (high noble metal)	$461
D6063	Abutment supported cast metal crown (predominantly base metal)	$412
D6064	Abutment supported cast metal crown (noble metal)	$451
D6065	Implant supported porcelain/ceramic crown	$461
D6066	Implant supported crown - porcelain fused to high noble alloys	$461
D6067	Implant supported crown - high noble alloys	$461
D6068	Abutment supported retainer for porcelain/ceramic FPD	$461
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$461
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$412
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$451
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$461
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$412
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$451
D6075	Implant supported retainer for ceramic FPD	$461

D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$461
D6077	Implant supported retainer for metal FPD - high noble alloys	$461
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	$175
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$412
D6083	Implant supported crown - porcelain fused to noble alloys	$451
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$461
D6086	Implant supported crown - predominantly base alloys	$412
D6087	implant supported crown - noble alloys	$451
D6088	Implant supported crown - titanium and titanium alloys	$461
D6091	Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$155
D6092	Re-cement or re-bond implant/abutment supported crown	$20
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$20
D6094	Abutment supported crown - titanium and titanium alloys	$461
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$461
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$412
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$451
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$158
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$158
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure	$180
D6104	Bone graft at time of implant placement	$22
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	$590
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	$590
D6112	Implant/abutment supported removable denture for partially edentulous arch – Maxillary	$687
D6113	Implant/abutment supported removable denture for partially edentulous arch – Mandibular	$687
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$412
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$412
D6122	Implant supported retainer for metal FPD - noble alloys	$451
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$461
D6193	Replacement of an implant screw - *limited to once in a two-year period*	$27
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$461
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$461
D6196	Removal of an indirect restoration on an implant retained abutment	$0
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$27

Prosthodontics (fixed) (each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)
- When a retainer crown and/or pontic exceeds six units in the same treatment plan, a Participant may be charged an additional $135.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be more than five years old.

ADACode	Procedure	Patient Pays
D6205	Pontic - indirect resin based composite	$350
D6210	Pontic - cast high noble metal	$410
D6211	Pontic - cast predominantly base metal	$360
D6212	Pontic - cast noble metal	$399
D6214	Pontic – titanium and titanium alloys	$410
D6240	Pontic - porcelain fused to high noble metal	$410
D6241	Pontic - porcelain fused to predominantly base metal	$360
D6242	Pontic - porcelain fused to noble metal	$399

D6243	Pontic - porcelain fused to titanium and titanium alloys	$300
D6245	Pontic - porcelain/ceramic	$360
D6250	Pontic - resin with high noble metal	$399
D6251	Pontic - resin with predominantly base metal	$350
D6252	Pontic - resin with noble metal	$389
D6253	Interim pontic - further treatment or completion of diagnosis necessary prior to final impression *(interim of at least 6 months)*	$200
D6545	Retainer - cast metal, resin bonded fixed prosthesis	$236
D6548	Retainer - porcelain/ceramic, resin bonded fixed prosthesis	$236
D6549	Retainer - for resin bonded fixed prosthesis	$236
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$297
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$297
D6602	Retainer inlay - cast high noble metal, two surfaces	$200
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$230
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$170
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$200
D6606	Retainer inlay - cast noble metal, two surfaces	$190
D6607	Retainer inlay - cast noble metal, three or more surfaces	$220
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$317
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$317
D6610	Retainer onlay - cast high noble metal, two surfaces	$280
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$290
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$250
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$260
D6614	Retainer onlay - cast noble metal, two surfaces	$270
D6615	Retainer onlay - cast noble metal, three or more surfaces	$280
D6624	Retainer inlay - titanium	$200
D6634	Retainer onlay - titanium	$280
D6710	Retainer crown - indirect resin based composite	$260
D6720	Retainer crown - resin with high noble metal	$368
D6721	Retainer crown - resin with predominantly base metal	$260
D6722	Retainer crown - resin with noble metal	$299
D6740	Retainer crown - porcelain/ceramic	$410
D6750	Retainer crown - porcelain fused to high noble metal	$410
D6751	Retainer crown - porcelain fused to predominantly base metal	$360
D6752	Retainer crown - porcelain fused to noble metal	$399
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$410
D6780	Retainer crown - 3/4 cast high noble metal	$399
D6781	Retainer crown - 3/4 cast predominantly base metal	$350
D6782	Retainer crown - 3/4 cast noble metal	$389
D6783	Retainer crown - 3/4 porcelain/ceramic	$350
D6784	Retainer crown - 3/4 titanium and titanium alloys	$410
D6790	Retainer crown - full cast high noble metal	$410
D6791	Retainer crown - full cast predominantly base metal	$360
D6792	Retainer crown - full cast noble metal	$399
D6793	Interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression *(interim of at least six months)*	$200
D6794	Retainer crown titanium and titanium alloys	$410
D6930	Re-cement or re-bond fixed partial denture *(by original dentist)*	$0
D6930	Re-cement or re-bond fixed partial denture *(by new dentist)*	$15
D6940	Stress breaker	$148
D6950	Precision attachment	$145
D6980	Fixed partial denture repair necessitated by restorative material failure	$123

Extractions/Oral and Maxillofacial Surgery

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

ADACode	Procedure	Patient Pays
D7111	Extraction of coronal remnants - primary tooth	$15
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$28
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$42
D7220	Removal of impacted tooth - soft tissue	$64
D7230	Removal of impacted tooth - partially bony	$78
D7240	Removal of impacted tooth - completely bony	$115
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$126
D7250	Removal of residual tooth roots (cutting procedure)	$50
D7252	Partial extraction for immediate implant placement, *limited to once per lifetime*	$42
D7280	Exposure of an unerupted tooth	$90
D7282	Mobilization of erupted or malposed tooth to aid eruption	$75
D7283	Placement of device to facilitate eruption of impacted tooth	$18
D7284	Excisional biopsy of minor salivary glands	$150
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$150
D7286	Incisional biopsy of oral tissue-soft	$150
D7287	Exfoliative cytological sample collection	$40
D7288	Brush biopsy - transepithelial sample collection	$40
D7294	Placement of temporary anchorage device without flap	$50
D7300	Removal of temporary anchorage device without flap	$0
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$45
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$25
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$75
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$38
D7471	Removal of lateral exotosis (maxilla or mandible)	$150
D7472	Removal of torus palatinus	$150
D7473	Removal of torus mandibularis	$150
D7485	Reduction of osseous tuberosity	$150
D7510	Incision and drainage of abscess - Intraoral soft tissue	$35
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$38
D7520	Incision and drainage of abscess - extraoral soft tissue	$40
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$44
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$0
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$150
D7953	Bone replacement graft for ridge preservation - *limited to once per lifetime per tooth*	$18
D7961	Buccal / labial frenectomy (frenulectomy)	$84
D7962	Lingual frenectomy (frenulectomy)	$84
D7963	Frenuloplasty	$86
D7970	Excision hyperplastic tissue - per arch	$100
D7972	Surgical reduction of fibrous tuberosity	$50

Adjunctive General Services

ADACode	Procedure	Patient Pays
D9110	Palliative treatment of dental pain - per visit	$15
D9120	Fixed partial denture sectioning	$125
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0

D9230	Administration of nitrous oxide	$10
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$30
D9450	Case presentation, subsequent detailed and extensive treatment planning	$0
D9942	Repair and/or reline of occlusal guard	$39
D9944	Occlusal guard - hard appliance, full arch	$150
D9945	Occlusal guard - soft appliance, full arch	$150
D9946	Occlusal guard - hard appliance, partial arch	$150
D9951	Occlusal adjustment - limited	$10
D9952	Occlusal adjustment - complete	$40
D9990	Certified translation or sign-language services - per visit	$0
D9995	Teledentistry - synchronous; real-time encounter	$0
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	$0
D9997	Dental case management - patients with special health care needs	$0
D9999	Unspecified adjunctive procedure, by report*	$0*

*A sterilization fee, not to exceed $7, may be charged to the Participant (under code D9999).

Orthodontic Services

The listed Copayment covers up to 24 months of active treatment, elastics, retainer adjustments, up to three reattached brackets and bands, up to three broken ligature wire replacements.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.
- Treatment plans extending beyond 24 months of active treatment, or 24 months of the retention phase of treatment, will be subject to a monthly office visit fee to the Participant at the Orthodontist's submitted fee.

Pre-orthodontic records include:

ADACode	Procedure	Patient Pays
The Copayment for pre-treatment records and diagnostic services (includes below services):		$200
D0210	Intraoral – complete services of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric image – acquisition, measurement and analysis	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	
D0396	3D printing of a 3D dental surface scan	
D0470	Diagnostic casts	
D0801	3D dental surface scan - direct	
D0802	3D dental surface scan - indirect	
D0803	3D facial surface scan - direct	
D0804	3D facial surface scan - indirect	

Orthodontic services include:

ADACode	Procedure	Patient Pays
D8010	Limited orthodontic treatment of the primary dentition	$500
D8020	Limited orthodontic treatment of the transitional dentition (to age 19)	$500
D8070	Comprehensive Orthodontic treatment of the transitional dentition (to age 19)	$1,800
D8080	Comprehensive Orthodontic treatment of the adolescent dentition (to age 19)	$2,100
D8090	Comprehensive Orthodontic treatment of the adult dentition	$2,100
D8091	Comprehensive orthodontic treatment with orthognathic surgery	$2,415
D8220	Fixed appliance therapy	$250
D8660	Pre-orthodontic treatment examination to monitor growth and development	$0

D8670	Periodic orthodontic treatment visit – included in comprehensive case fee	$0
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$100
D8681	Removable orthodontic retainer adjustment	$0
D8999	Unspecified orthodontic procedure, by report (includes consultation and treatment planning session)	$126

Post-orthodontic records include:
The Copayment for post-treatment records includes: $0

D0210 Intraoral – complete services of radiographic images
D0470 Diagnostic casts

NOTE:
1. Not all participating dentists perform all listed procedures, including amalgams. Please consult Your dentist prior to treatment for availability of services.
2. Some Covered Dental Care Services are typically only offered by a specialist (like many oral surgery procedures).
3. When crown and/or bridgework exceeds six units in the same treatment plan, the Participant may be charged an additional $135 per unit, beyond the sixth unit.
4. Additional exclusions and limitations are listed along with full plan information in Your Evidence of Coverage (“EOC”).
5. Copayment amounts for listed procedures are applicable at the Participating General Dentist. If You should need to see a specialist (i.e. endodontist, oral surgeon, periodontist, pediatric dentist), upon identification of yourself as a Participant, You will receive a 25% reduction from the Participating Specialist’s usual fee for Covered Dental Care Services performed

Offered and Administered by DentiCare, Inc. (d/b/a CompBenefits), a Humana company

Notice of Non-Discrimination. Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex. Humana and its subsidiaries provide people with disabilities reasonable modifications and free communication aids to allow for effective communication with us such as written information in other formats (large print, audio, accessible electronic formats, other formats). Humana and its subsidiaries also provide free language assistance services to people whose first language is not English such as qualified interpreters, and written information in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services, contact Humana Inc. and its subsidiaries at **877-320-1235 (TTY: 711)**. Hours of operations: 8 a.m. - 8 p.m., Eastern time.

If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, phone, or email with Humana Inc.'s Non-Discrimination Coordinator:

Mail:
P.O. Box 14618
Lexington, KY 40512-4618

Phone: **877-320-1235 (TTY: 711),**

Email: **accessibility@humana.com**

If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

Mail:
Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building, Washington, DC 20201

Email: **OCRComplaint@hhs.gov**

Phone: **800-368-1019**, **800-537-7697 (TTY/TDD)**.

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

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m., Eastern time. Humana Inc. and its subsidiaries provide free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 **(Korean):** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Italiano (Italian): Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

हिंदी (Hindi): भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें।

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

اردو (Urdu): مفت زبان مدد کی خدمات حاصل کرنے کے لیے اوپر دیے گئے نمبر پر کال کریں۔

These notices are available at **www.humana.com/legal/non-discrimination-disclosure** and **www.humana.com/legal/multi-language-support.**