PacificSource HEALTH PLANS

Medical Benefit Summary
Navigator 100_10 S3

Graduate Teaching Fellows Federation

Benefit Year: Contract Year

Provider Network: Navigator

Deductible Per Benefit Year	In-network and Out-of-network	
Individual/Family	$100/$300	
Out-of-Pocket Limit Per Benefit Year	**In-network**	**Out-of-network**
Individual/Family	$2,200/$4,400	$3,300/Not applicable

Note: In-network out-of-pocket limit accumulates separately from the out-of-network out-of-pocket limit. Even though you may have the same benefit for in-network and out-of-network, your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers may in certain circumstances bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see your handbook.

Accident Benefit

Covered services within 90 days of an accident is covered and not subject to the deductible. The date of injury must occur after the member is enrolled in this plan. If date of injury occurred prior to being enrolled on this plan, this benefit will not apply. The balance is covered as shown below.

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	UHC In-network Member Pays	In-network Member Pays	Out-of-network Member Pays
Preventive Care			
Well baby/Well child care	No deductible, 0%	No deductible, 0%	After deductible, 30%
Preventive physicals	No deductible, 0%	No deductible, 0%	After deductible, 30%
Well woman visits	No deductible, 0%	No deductible, 0%	After deductible, 30%
Preventive mammograms	Not available	No deductible, 0%	After deductible, 30%
Immunizations	No deductible, 0%	No deductible, 0%	After deductible, 30%
Preventive colonoscopy	Not available	No deductible, 0%	After deductible, 30%
Prostate cancer screening	Not available	No deductible, 0%	After deductible, 30%
Professional Services			
Office and home visits	No deductible, 0%	First three visits no deductible, 0%.	After deductible, 30%

Service/Supply	UHC In-network Member Pays	In-network Member Pays	Out-of-network Member Pays
		Subsequent visits, after deductible, 10%*	
Naturopath office visits	Not available	After deductible, 10%	After deductible, 30%
Specialist office and home visits	No deductible, 0%	After deductible, 10%	After deductible, 30%
Telehealth visits	No deductible, 0%	First three visits no deductible, 0%. Subsequent visits, after deductible, 10%*	After deductible, 30%
Office procedures and supplies	No deductible, 0%	After deductible, 10%	After deductible, 30%
Surgery	Not available	After deductible, 10%	After deductible, 30%
Outpatient rehabilitation and habilitation services	No deductible, 10%	No deductible, 10%	No deductible, 30%
Acupuncture (20 visits per benefit year)	No deductible, 10%	No deductible, 10%	No deductible, 30%
Chiropractic manipulation/Spinal manipulation (25 visits per benefit year)	No deductible, 10%	No deductible, 10%	No deductible, 30%
Massage therapy (40 visits per benefit year)	No deductible, 10%	No deductible, 10%	No deductible, 30%
Hospital Services			
Inpatient room and board	Not available	After deductible, 10%	After deductible, 30%
Inpatient rehabilitation and habilitation services	Not available	After deductible, 10%	After deductible, 30%
Skilled nursing facility care	Not available	After deductible, 10%	After deductible, 30%
Outpatient Services			
Outpatient surgery/services	Not available	After deductible, 10%	After deductible, 30%
Diagnostic imaging – advanced	No deductible, 0%	After deductible, 10%	After deductible, 30%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	No deductible, 0%	After deductible, 10%	After deductible, 30%
Urgent and Emergency Services			
Urgent care center visits	Not available	After deductible, 10%	After deductible, 30%
Emergency room visits – medical emergency	Not available	After deductible, $50 plus 10%^	After deductible, $50 plus 10%^
Emergency room visits – non-emergency	Not available	After deductible, $50 plus 10%^	After deductible, $50 plus 10%^
Ambulance, ground	Not available	After deductible, 20%	After deductible, 20%

Service/Supply	UHC In-network Member Pays	In-network Member Pays	Out-of-network Member Pays
Ambulance, air	Not available	After deductible, 20%	After deductible, 20%
Maternity Services**			
Physician/Provider services (global charge)	Not available	After deductible, 10%	After deductible, 30%
Hospital/Facility services	Not available	After deductible, 10%	After deductible, 30%
Mental Health and Substance Use Disorder Services			
Office visits	Not available	First three visits no deductible, 0%. Subsequent visits, no deductible, 10%*	No deductible, 30%
Inpatient care	Not available	After deductible, 10%	After deductible, 30%
Residential programs	Not available	After deductible, 10%	After deductible, 30%
Other Covered Services			
Allergy injections	No deductible, 0%	After deductible, 10%	After deductible, 30%
Durable medical equipment	No deductible, 0%	After deductible, 10%	After deductible, 30%
Home health services	Not available	After deductible, 10%	After deductible, 30%
Transplants	Not available	After deductible, 0%	After deductible, 40%
Infertility	Not available	After deductible, 50%	After deductible, 50%

This is a brief summary of benefits. Refer to your handbook for additional information or a further explanation of benefits, limitations, and exclusions.

^ Copay applies to ER physician and facility charges only. Copay waived if admitted into hospital.

* First 3 visits per benefit year combined for Professional Services – Office and home visits, Telehealth visits, and Mental Health and Substance Use Disorder Services – Office visits.

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a deductible, copayment, or coinsurance.

Additional information

What is the deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that many services, especially preventive care, are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met.

In-network expense and out-of-network expense apply together toward your deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered services during the benefit year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of allowed amounts for covered services for the rest of that benefit year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limit applies for each member only until the family out-of-pocket limit has been met. Be sure to check your handbook, as there are some charges, such as non-essential health benefits, penalties, and balance billed amounts that do not count toward the out-of-pocket limit.

Note that there is a separate category for in-network and out-of-network when it comes to meeting your out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior authorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and out-of-network providers. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

PacificSource Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PacificSource HEALTH PLANS

Prescription Drug Benefit Summary
OR 30P S2 ODL

Graduate Teaching Fellows Federation

Benefit Year: Contract Year

Formulary: Oregon Drug List (ODL)

This plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This plan complies with federal healthcare reform. To check which tier your prescription falls under, call our Customer Service team or visit PacificSource.com/find-a-drug.

The amount you pay for covered prescriptions at in-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, the amount you pay for covered prescriptions at out-of-network pharmacies applies toward your plan's out-of-network out-of-pocket limit which is shown on the Medical Benefit Summary. The copayment and/or coinsurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the benefit year in which you have satisfied the medical out-of-pocket limit.

PacificSource Expanded (Preventive) No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0 copay. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com and select Find a Drug.

Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes preventive care drugs at no cost to you and are not subject to a deductible or MAC penalties. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the drug list as Tier 0.

Each time a covered prescription is dispensed, you are responsible for any amounts shown above, in addition to the following amounts:

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
In-network Retail Pharmacy				
Up to a 30 day supply:	No deductible, 30%	No deductible, 30%*	No deductible, 30%*	No deductible, the lesser of $300 or 30%
31 – 60 day supply:	No deductible, 30%	No deductible, 30%	No deductible, 30%	No deductible, the lesser of $600 or 30%
61 – 90 day supply:	No deductible, 30%	No deductible, 30%	No deductible, 30%	No deductible, the lesser of $900 or 30%
In-network Mail Order Pharmacy				
Up to a 30 day supply:	No deductible, 30%	No deductible, 30%*	No deductible, 30%*	No deductible, the lesser of $300 or 30%

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
31 – 60 day supply:	No deductible, 30%	No deductible, 30%	No deductible, 30%	No deductible, the lesser of $600 or 30%
61 – 90 day supply:	No deductible, 30%	No deductible, 30%	No deductible, 30%	No deductible, the lesser of $900 or 30%
Compound Drugs**				
Up to a 30 day supply:	No deductible, 30%			
31 – 60 day supply:	No deductible, 30%			
61 – 90 day supply:	No deductible, 30%			
Out-of-network Pharmacy				
30 day maximum fill, no more than three fills allowed per year:	No deductible, 50%			

*Formulary prescription insulin will not be subject to a deductible and limited to $85 copay per 30 day supply.

**Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

Specialty Medications must be filled through an in-network specialty pharmacy and are limited to a 30 day supply.

MAC B - Unless the prescribing provider requires the use of a brand name drug, the prescription will automatically be filled with a generic drug when available and permissible by state law. If you receive a brand name drug when a generic is available, you will be responsible for the brand name drug's copayment and/or coinsurance plus the difference in cost between the brand name drug and its generic equivalent. If your prescribing provider requires the use of a brand name drug, the prescription will be filled with the brand name drug and you will be responsible for the brand name drug's copayment and/or coinsurance. The cost difference between the brand name and generic drug does not apply toward the medical out-of-pocket limit. Does not apply to preventive bowel prep kits covered under USPSTF guidelines.

If your provider prescribes a brand name contraceptive due to medical necessity it may be subject to prior authorization for coverage at no charge.

See your handbook for important information about your prescription drug benefit, including which drugs are covered, limitations, and more.

PacificSource HEALTH PLANS

Graduate Teaching Fellows Federation

Vision Benefit Summary
Vision 10-300

Benefit Year: Contract Year

The following shows the vision benefits available under this plan for all covered vision exams, lenses, and frames when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Coverage for pediatric services will end on the last day of the month in which the member turns 19. Copayment and/or coinsurance for covered charges apply to the medical plan's out-of-pocket limit.

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Members Age 18 and Younger		
Eye exam	No deductible, $10	No deductible up to $40 then 100%
Vision hardware	No deductible, 0% for one pair per year for frames or lenses	No deductible, 0% for one pair per year up to $75 then 100% for frames and/or lenses
Members Age 19 and Older		
Eye exam	No deductible, $10	No deductible up to $40 then 100%
Vision hardware	No deductible, 0% up to $300	

Benefit Limitations: members age 18 and younger

- One vision exam every benefit year.
- Vision hardware includes glasses (lenses and frames) or contacts (lenses and fitting) once per benefit year.

Benefit Limitations: members age 19 and older

- One vision exam every benefit year.
- Vision hardware includes glasses (lenses and frames) and/or contacts (lenses and fitting). Benefit maximum is per benefit year.
- Anti-reflective coatings and scratch resistant coatings are covered.

Exclusions

- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by an employer.
- Expenses covered under any workers' compensation law.
- Eye exams required as a condition of employment, required by a labor agreement or government body.
- Medical or surgical treatment of the eye.
- Nonprescription lenses.
- Plano contact lenses.

- Services or supplies not listed as covered services.
- Services or supplies received before this plan's coverage begins or after it ends.
- Special procedures, such as orthoptics or vision training.
- Visual analysis that does not include refraction.

Important information about your vision benefits

Your plan includes coverage for vision services. To make the most of those benefits, it's important to keep in mind the following:

In-network Providers: PacificSource is able to add value to your vision benefits by contracting with a network of vision providers. Those providers offer vision services at discounted rates, which are passed on to you in your benefits.

Paying for Services: Our provider contracts require in-network providers to bill us directly whenever you receive covered services and supplies. Providers will verify your vision benefits.

In-network providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as copayments and amounts over your plan's maximum benefit. If you are asked to pay the entire amount in advance, tell the provider you understand they have a contract with PacificSource and they should bill PacificSource directly.

Sales and Special Promotions (sales and promotions are not considered insurance): Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because in-network providers already discount their services through their contract with PacificSource, your plan's in-network benefits cannot be combined with any other discounts or coupons. You can use your plan's in-network benefits, or you can use your plan's out-of-network benefits to take advantage of a sale or coupon offer.

If you do take advantage of a special offer, the in-network provider may treat you as an uninsured customer and require full payment in advance. You can then send the claim to PacificSource yourself, and we will reimburse you according to your plan's out-of-network benefits.

PacificSource HEALTH PLANS

GTFF - PPO

Dental Benefit Summary
Dental PPO "Plus"

Benefit Year: Contract Year

This plan covers the following services when performed by a provider to the extent that they are operating within the scope of their license as required under law in the state of issuance, and when determined to be necessary, usual, and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function (chewing of food).

In-network dentists contract with PacificSource to furnish dental services and supplies for a set fee. That fee is called the allowable fee. In-network providers agree not to collect more than the allowable fee. When you use an in-network provider, you will pay only the in-network provider amounts below. If you choose not to use an in-network provider, or don't have access to one, reimbursement is based on the allowable fee. If charges exceed the allowable fee, the excess charges are your responsibility.

Deductible Per Benefit Year	In-network	Out-of-network
Individual/Family	None/None	$50 / $150
Benefit Maximum Per Benefit Year		
$1,500 per individual. Applies to all covered services.		
Exclusion Period	**Number of Consecutive Months**	
Class II Services	None	
Class III Services	None	

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Class I Services		
Examinations	No deductible, 0%	No deductible, 0%
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 0%	No deductible, 0%
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 0%	No deductible, 0%
Fluoride (topical or varnish applications)	No deductible, 0%	No deductible, 0%
Sealants	No deductible, 0%	No deductible, 0%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Space maintainers	No deductible, 0%	No deductible, 0%
Athletic mouth guards	No deductible, 0%	No deductible, 0%
Brush biopsies	No deductible, 0%	No deductible, 0%
Class II Services		
Fillings	No deductible, 20%	After deductible, 20%
Simple extractions	No deductible, 20%	After deductible, 20%
Periodontal scaling and root planing	No deductible, 20%	After deductible, 20%
Full mouth debridement	No deductible, 20%	After deductible, 20%
Complicated oral surgery	No deductible, 20%	After deductible, 20%
Pulp capping	No deductible, 20%	After deductible, 20%
Pulpotomy	No deductible, 20%	After deductible, 20%
Root canal therapy	No deductible, 20%	After deductible, 20%
Periodontal surgery	No deductible, 20%	After deductible, 20%
Tooth desensitization	No deductible, 20%	After deductible, 20%
Class III Services		
Crowns	No deductible, 40%	After deductible, 40%
Dentures	No deductible, 40%	After deductible, 40%
Bridges	No deductible, 40%	After deductible, 40%
Replacement of existing prosthetic device	No deductible, 40%	After deductible, 40%
Implants	No deductible, 40%	After deductible, 40%

This is a brief summary of benefits. Refer to your handbook for additional information or a further explanation of benefits, limitations, and exclusions.

Additional information

What is the deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that some services are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met.

What is the benefit maximum?

The benefit maximum is the maximum amount payable by this plan for covered services received each benefit year.

What is an exclusion period?

A member must be enrolled under the plan for the period of time stated above before this plan pays benefits. The exclusion period is waived for members who are covered under this plan on the plan's original effective date if the member was continuously covered under a predecessor plan of the employer.

Prior authorization

Coverage of certain services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

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Benefit Year: Contract Year

The member is responsible for the following amounts:

ADA Code Procedure	Member Pays
General Office Visit Charge	$25
Specialist Office Visit Charge	$30
Emergency Office Visit Charge	$50
Diagnostic and Preventive Services	
D0120 - Periodic oral evaluation	No co-pay
D0140 - Limited oral evaluation – problem focused	No co-pay
D0145 - Oral evaluation – patient under three years old	No co-pay
D0150 - Comprehensive oral evaluation	No co-pay
D0160 - Detailed and extensive oral evaluation	No co-pay
D0170 - Re-evaluation – limited	No co-pay
D0171 - Re-evaluation – post operative office visit	No co-pay
D0180 - Comprehensive periodontal evaluation	No co-pay
D0191 - Assessment of a patient	No co-pay
D0210 - Complete series x-rays	No co-pay
D0220 - Periapical – first film	No co-pay
D0230 - Intraoral – each additional film	No co-pay
D0240 - Intraoral – occlusal film	No co-pay
D0250 - Extraoral – first film	No co-pay
D0251 - Extraoral – posterior dental radiographic image	No co-pay
D0270 - Bitewings – single film	No co-pay
D0272 - Bitewings – two films	No co-pay
D0273 - Bitewings – three films	No co-pay
D0274 - Bitewings – four films	No co-pay

ADA Code Procedure	Member Pays
D0277 - Vertical bitewings	No co-pay
D0310 - Sialography	Not covered
D0320 - Temporomandibular joint arthrogram	Not covered
D0321 - Other Temporomandibular joint films	Not covered
D0322 - Tomographic survey	Not covered
D0330 - Panoramic x-rays	No co-pay
D0340 - Cephalometric film	No co-pay
D0350 - Oral/facial images	No co-pay
D0364 - Cone beam CT, limited view	No co-pay
D0365 - Cone beam CT, full arch – mandible	Not covered
D0366 - Cone beam CT, full arch – maxilla	Not covered
D0367 - Cone beam CT, both jaws	No co-pay
D0368 - Cone beam CT, Temporomandibular joint series	Not covered
D0391 - Interpret and report diagnostic image	Not covered
D0415 - Collection of microorganisms for culture and sensitivity	Not covered
D0425 - Caries susceptibility test	No co-pay
D0460 - Pulp vitality test	No co-pay
D0470 - Diagnostic casts	No co-pay
D1110 - Teeth cleaning (prophylaxis) – adult	No co-pay
D1120 - Teeth cleaning (prophylaxis) – child	No co-pay
D1206 - Topical fluoride – therapeutic application	No co-pay
D1208 - Topical fluoride	No co-pay
D1310 - Nutritional counseling	No co-pay
D1320 - Tobacco counseling	No co-pay
D1330 - Oral hygiene instruction	No co-pay
D1351 - Sealant – per tooth	No co-pay
D1353 - Sealant repair – per tooth	No co-pay

ADA Code Procedure	Member Pays
D1354 - Interim caries arresting medicament application	No co-pay
Space Maintainers	
D1510 - Space maintainer – unilateral – fixed	No co-pay
D1516 - Space maintainer – fixed – bilateral, maxillary	No co-pay
D1517 - Space maintainer – fixed – bilateral, mandibular	No co-pay
D1520 - Space maintainer – unilateral – removable	No co-pay
D1526 - Space maintainer – removable – bilateral, maxillary	No co-pay
D1527 - Space maintainer – removable – bilateral, mandibular	No co-pay
D1551 - Re-cement or re-bond bilateral space maintainer – maxillary	No co-pay
D1552 - Re-cement or re-bond bilateral space maintainer – mandibular	No co-pay
D1553 - Re-cement or re-bond bilateral space maintainer – per quadrant	No co-pay
D1556 - Removal of fixed unilateral space maintainer – per quadrant	No co-pay
D1557 - Removal of fixed unilateral space maintainer – maxillary	No co-pay
D1558 - Removal of fixed unilateral space maintainer – mandibular	No co-pay
Restorative Dentistry - Amalgam Restorations	
D2140 - Fillings – one surface	No co-pay
D2150 - Fillings – two surfaces	No co-pay
D2160 - Fillings – three surfaces	No co-pay
D2161 - Fillings – four or more surfaces	No co-pay
Restorative Dentistry - Resin Restorations	
D2330 - Resin – one surface – anterior	No co-pay
D2331 - Resin – two surfaces – anterior	No co-pay
D2332 - Resin – three surfaces – anterior	No co-pay

ADA Code Procedure	Member Pays
D2335 - Resin – four or more surfaces – anterior	No co-pay
D2390 - Resin based composite crown	$60
D2391 - Resin – one surface – posterior	$60
D2392 - Resin – two surfaces – posterior	$60
D2393 - Resin – three surfaces – posterior	$60
D2394 - Resin – four or more surfaces – posterior	$60
D2950 - Core buildup, including any pins	No co-pay
Restorative Dentistry - Inlay/Onlay (cast restorations)	
D2510 - Inlay – gold – one surface	$200
D2520 - Inlay – gold – two surfaces	$200
D2530 - Inlay – gold – three or more surfaces	$200
D2542 - Onlay – gold – two surfaces	$200
D2543 - Onlay – gold – three surfaces	$200
D2544 - Onlay – gold – four or more surfaces	$200
D2610 - Inlay – porcelain/ceramic – one surface	$200
D2620 - Inlay – porcelain/ceramic – two surfaces	$200
D2630 - Inlay – porcelain/ceramic – three or more surfaces	$200
D2642 - Onlay – porcelain/ceramic – two surfaces	$200
D2643 - Onlay – porcelain/ceramic – three surfaces	$200
D2644 - Onlay – porcelain/ceramic – four or more surfaces	$200
D2910 - Re-cement inlay, onlay, or partial coverage restoration	No co-pay
Restorative Dentistry - Crowns	
D2710 - Crown – resin laboratory	$200
D2712 - Crown – ¾ resin-based composite	$200
D2740 - Crown – porcelain/ceramic – anterior	$200
D2751 - Crown – porcelain fused to base metal	$200
D2752 - Crown – porcelain/noble	$200

ADA Code Procedure	Member Pays
D2753 - Crown – porcelain fused to titanium or titanium alloy	$200
D2782 - Crown – ¾ cast noble	$200
D2792 - Crown – full cast noble	$200
D2799 - Provisional crown	No co-pay
D2915 - Re-cement cast or prefabricated post and core	No co-pay
D2920 - Re-cement crown	No co-pay
D2930 - Stainless steel crown – primary	No co-pay
D2931 - Stainless steel crown – permanent	No co-pay
D2932 - Crown – prefabricated resin	No co-pay
D2933 - Crown – prefabricated stainless steel with resin window	No co-pay
D2940 - Sedative filling – temporary	No co-pay
D2950 - Core buildup, including any pins	No co-pay
D2951 - Pin retention – per tooth, in addition to restoration	No co-pay
D2954 - Prefabricated dowel post and core	No co-pay
D2955 - Post removal (no endodontic therapy)	No co-pay
D2957 - Each additional prefabricated post – same tooth	No co-pay
D2980 - Repair crown	No co-pay
Endodontics	
D3110 - Pulp cap – direct excluding final restoration	No co-pay
D3120 - Pulp cap – indirect excluding final restoration	No co-pay
D3220 - Pulpotomy	No co-pay
D3221 - Gross pulpal debridement – primary and permanent teeth	No co-pay
D3222 - Partial pulpotomy for apexogenesis	Not covered
D3230 - Pulpal therapy – primary anterior	No co-pay
D3240 - Pulpal therapy – primary posterior	No co-pay
D3310 - Root canal therapy – anterior	$200

ADA Code Procedure	Member Pays
D3320 - Root canal therapy – bicuspid	$200
D3330 - Root canal therapy – molar	$200
D3331 - Treatment of root canal obstruction – non-surgical access	No co-pay
D3332 - Incomplete endodontic therapy – inoperable or fractured tooth	No co-pay
D3333 - Internal repair of perforation defects	No co-pay
D3346 - Retreatment – anterior	$200
D3347 - Retreatment – bicuspid	$200
D3348 - Retreatment – molar	$200
D3351 - Apexification – initial visit	$200
D3352 - Apexification – interim visit	No co-pay
D3353 - Apexification – final visit	No co-pay
D3410 - Apicoectomy – anterior	$200
D3421 - Apicoectomy – bicuspid first root	$200
D3425 - Apicoectomy – molar first root	$200
D3426 - Apicoectomy – each additional root	No co-pay
D3430 - Retrograde filling – per root	No co-pay
D3450 - Root amputation per root	$200
D3920 - Hemisection	$200
D3950 - Canal prep – preformed dowel/post	No co-pay
Note: The treatment of a root canal or apical surgery performed within 24 months of initial treatment is considered part of the initial treatment charge. Thereafter, re-treatment of a root canal may be subject to an additional charge.	
Periodontics	
D4210 - Gingivectomy or gingivoplasty – four or more teeth	$150
D4211 - Gingivectomy – one to three teeth	$150
D4240 - Gingival flap – four or more teeth	$200

ADA Code Procedure	Member Pays
D4241 - Gingival flap – one to three teeth	$200
D4249 - Crown lengthening hard tissue	$200
D4260 - Osseous surgery – four or more teeth	$200
D4261 - Osseous surgery – one to three teeth	$200
D4263 - Bone replacement graft – first site in quadrant	$200
D4264 - Bone replacement graft – each additional site in quadrant	No co-pay
D4270 - Pedicle soft tissue graft procedure	$200
D4273 - Subepithelial connective graft	$200
D4274 - Distal wedge procedure	$200
D4277 - Free soft tissue graft – first tooth or edentulous tooth position	$200
D4341 - Periodontic scale and root plane – four or more teeth	$150
D4342 - Periodontic scale and root plane – one to three teeth	$150
D4355 - Full-mouth debridement	No co-pay
D4381 - Antimicrobial irrigation	No co-pay
D4910 - Periodontal maintenance following therapy	No co-pay
D4920 - Unscheduled dressing change	Not covered
Prosthondontics - Removable	
D5110 - Complete (upper denture)	$150
D5120 - Complete (lower denture)	$150
D5130 - Immediate (upper denture)	$150
D5140 - Immediate (lower denture)	$150
D5211 - Upper partial resin base	$150
D5212 - Lower partial resin base	$150
D5213 - Upper partial cast metal frame	$150
D5214 - Lower partial cast metal frame	$150

ADA Code Procedure	Member Pays
D5221 - Immediate maxillary partial denture – resin base	$150
D5222 - Immediate mandibular partial denture – resin base	$150
D5223 - Immediate maxillary partial denture – cast metal framework with resin denture bases	$150
D5224 - Immediate mandibular partial denture – cast metal framework with resin denture bases	$150
D5225 - Upper partial flexible base	Not covered
D5226 - Lower partial flexible base	Not covered
D5282 - Removable unilateral partial denture – one piece cast metal (including clasps and teeth) – maxillary	$150
D5283 - Removable unilateral partial denture – one piece cast metal (including clasps and teeth) – mandibular	$150
D5284 - Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	$150
D5286 - Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	$150
D5410 - Adjustment – complete denture, upper	No co-pay
D5411 - Adjustment – complete denture, lower	No co-pay
D5421 - Adjustment – partial denture, upper	No co-pay
D5422 - Adjustment – partial denture, lower	No co-pay
D5520 - Repair denture – replace missing or broken teeth (each tooth)	No co-pay
D5630 - Repair or replace partial clasp	No co-pay
D5640 - Replace teeth – partial per tooth	No co-pay
D5650 - Add tooth to existing partial	No co-pay
D5660 - Add clasp to existing partial	No co-pay
D5670 - Replace all teeth and acrylic on cast metal framework – maxillary	Not covered
D5671 - Replace all teeth and acrylic on cast metal framework – mandibular	Not covered
D5710 - Rebase complete upper denture	No co-pay
D5711 - Rebase complete lower denture	No co-pay

ADA Code Procedure	Member Pays
D5720 - Rebase upper partial	No co-pay
D5721 - Rebase lower partial	No co-pay
D5730 - Reline complete upper denture (chairside)	No co-pay
D5731 - Reline complete lower denture (chairside)	No co-pay
D5740 - Reline upper partial (chairside)	No co-pay
D5741 - Reline lower partial (chairside)	No co-pay
D5750 - Reline upper denture – lab	No co-pay
D5751 - Reline lower denture – lab	No co-pay
D5760 - Reline upper partial – lab	No co-pay
D5761 - Reline lower partial – lab	No co-pay
D5810 - Interim denture – upper	$100
D5811 - Interim denture – lower	$100
D5820 - Interim partial – upper	$100
D5821 - Interim partial – lower	$100
D5850 - Tissue conditioning – upper	No co-pay
D5851 - Tissue conditioning – lower	No co-pay
D5986 - Fluoride gel custom tray	No co-pay
Prosthondontics - Fixed	
D6210 - Pontic, cast (per tooth) traditional fixed partial dentures only	$200
D6240 - Pontic (per tooth); porcelain/metal traditional fixed partial dentures only (bridges)	$200
D6241 - Pontic (per tooth) Maryland bridge	$200
D6545 - Cast metal retainer	$200
D6549 - Resin retainer – for resin bonded fixed prosthesis	Not covered
D6720 - Crown – resin/metal abutment	$200
D6750 - Crown – porcelain metal abutment	$200
D6780 - Crown – ¾ cast metal abutment	$200
D6790 - Crown – full gold abutment	$200

ADA Code Procedure	Member Pays
D6975 - Coping – metal	No co-pay
D6980 - Bridge repair	No co-pay
Oral Surgery	
D7111 - Extraction coronal remnants primary tooth	No co-pay
D7140 - Extraction erupted tooth	No co-pay
D7210 - Surgical extraction – erupted	$150
D7220 - Removal of impacted tooth – soft tissue	$150
D7230 - Removal of impacted tooth – partial bony	$150
D7240 - Removal of impacted tooth – complete bony	$150
D7241 - Removal of impacted tooth – complete bony with complications	$150
D7250 - Surgical removal residual root	$150
D7251 - Coronectomy – intentional partial tooth removal	Not covered
D7260 - Oroantral fistula closure	$150
D7261 - Primary closure of sinus perforation	Not covered
D7270 - Tooth re-implantation	$150
D7280 - Surgical access unerupted tooth	$150
D7283 - Ortho bracket to aid eruption if plan covers orthodontia	$150
D7285 - Biopsy of oral tissue – hard (bone, tooth)	Not covered
D7286 - Biopsy of oral tissue – soft	Not covered
D7287 - Exfoliative cytological sample collection	Not covered
D7288 - Brush biopsy – transepithelial simple collection	No co-pay
D7291 - Transseptal fiberotomy	$150
D7310 - Alveoloplasty with extractions – per quadrant 4 or more	$150
D7320 - Alveoloplasty without extractions – per quadrant	$150
D7321 - Alveoloplasty not with extractions	$150
D7340 - Vestibuloplasty (secondary epithelialization)	$150

ADA Code Procedure	Member Pays
D7350 - Vestibuloplasty (including soft tissue grafts)	$150
D7450 - Remove benign odontogenic cyst up to 1.25 cm	$150
D7451 - Remove benign odontogenic cyst greater than 1.25 cm	$150
D7465 - Destruction of lesion(s) – physical or chemical method	$150
D7471 - Remove lateral exostosis	$150
D7510 - Incision and drainage of abscess – intraoral soft tissue	No co-pay
D7520 - Incision and drainage of abscess – extraoral soft tissue	No co-pay
D7530 - Remove foreign body – soft tissue	No co-pay
D7540 - Remove foreign body – hard tissue	No co-pay
D7550 - Partial ostectomy/sequestrectomy for removal of non vital bone	Not covered
D7560 - Maxillary sinusotomy for removal of tooth fragment	Not covered
D7670 - Stabilization splint – alveolus	No co-pay
D7770 - Alveolus – open reduction stabilization of teeth	Not covered
D7910 - Suture small wound up to 5 cm	No co-pay
D7911 - Complicated suture up to 5 cm	No co-pay
D7912 - Complicated suture greater than 5 cm	Not covered
D7940 - Osteoplasty	$150
D7953 - Bone replacement graft for ridge reservation – per site	$150
D7961 - Buccal/Labial frenectomy (frenulectomy)	$150
D7962 - Lingual frenectomy (frenulectomy)	$150
D7963 - Frenuloplasty	Not covered
D7970 - Excision hyperplastic tissue	$150
D7971 - Excision of pericoronal flap	$150
D7980 - Sialolithotomy	$150

ADA Code Procedure	Member Pays
D7981 - Excision of salivary gland	Not covered
D7982 - Sialodochoplasty	Not covered
D7983 - Closure of salivary fistula	Not covered
D7990 - Emergency tracheotomy	Not covered
D7997 - Appliance removal (not by dentist who placed appliance)	Not covered
Orthodontia	
D8010 - Limited orthodontic treatment of the primary dentition	Not covered
D8020 - Limited orthodontic treatment of the transitional dentition	Not covered
D8030 - Limited orthodontic treatment of the adolescent dentition	Not covered
D8040 - Limited orthodontic treatment of the adult dentition	Not covered
D8050 - Interceptive orthodontic treatment of the primary dentition	Not covered
D8060 - Interceptive orthodontic treatment of the transitional dentition	Not covered
D8070 - Comprehensive orthodontic treatment of the transitional dentition	$3,000
D8080 - Comprehensive orthodontic treatment of the adolescent dentition	$3,000
D8090 - Comprehensive orthodontic treatment of the adult dentition	$3,000
D8210 - Removable appliance therapy	Not covered
D8220 - Fixed appliance therapy	Not covered
D8660 - Pre-orthodontic treatment visit	$150^
D8670 - Periodic orthodontic treatment visit (as part of contract)	No co-pay
D8680 - Orthodontic retention (removal of appliances, construction)	No co-pay
D8681 - Removable orthodontic device adjustment	No co-pay

ADA Code Procedure	Member Pays
D8690 - Orthodontic treatment (alternative billing to a contract fee)	Not covered
D8691 - Repair of orthodontic appliance	Not covered
D8693 - Re-bonding or re-cementing; and/or repair, as required	No co-pay
D8698 - Re-cement or re-bond fixed retainer - maxillary	No co-pay
D8699 - Re-cement or re-bond fixed retainer – mandibular	No co-pay
Anesthesia	
D9210 - Local Anesthesia not in conjunction with operative or surgical procedures	Not covered
D9211 - Regional block anesthesia	Not covered
D9212 - Trigeminal division block anesthesia	Not covered
D9215 - Local anesthesia (Novocain)	No co-pay
D9222 - Deep sedation/general anesthesia – first 15 minutes	$100
D9223 - Deep sedation/general anesthesia – each subsequent 15 minute increment	Not covered
D9230 - Nitrous oxide (per visit)	$20
D9239 - Intravenous moderate (conscious) sedation – first 15 minutes	$100
D9243 - Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	Not covered
D9248 - Non-intravenous conscious sedation	Not covered
Miscellaneous	
D9110 - Palliative (emergency) minor	$50
D9120 - Fixed partial denture sectioning	Not covered
D9310 - Consultation – per session	No co-pay
D9410 - House/extended care facility call	Not covered
D9430 - Observation visit	No co-pay
D9440 - Emergency treatment – after office hours	No co-pay
D9610 - Therapeutic parenteral drug – single administration	Not covered

ADA Code Procedure	Member Pays
D9612 - Therapeutic parenteral drug – 2 or more	Not covered
D9630 - Other drugs and/or medicaments	Not covered
D9911 - Application of desensitizing medicaments	No co-pay
D9920 - Behavior management	Not covered
D9930 - Treatment of complications – post surgical	Not covered
D9944 - Occlusal guard – hard appliance, full arch	$100
D9945 - Occlusal guard – soft appliance, full arch	$50
D9951 - Occlusal adjustment – simple	No co-pay
D9952 - Occlusal adjustment – complete	No co-pay
Out-of-area emergency reimbursement	Reimbursed up to $100
Exclusions	
See Exclusion section of the Member Handbook	

^ Fee credited towards comprehensive orthodontic copayment if patient accepts treatment plan.