

Union Security Insurance Company

**GROUP DENTAL INSURANCE
SCHEDULE OF BENEFITS**

(to be attached to and made a part of the *policy* and certificate)

Policyholder: Wisconsin Evangelical Lutheran Synod

Policy Number: 5,298,449

Schedule of Benefits for use beginning on: January 1, 2008

(This date does not change the Effective Date of insurance shown in your certificate or the *policy*.)

For use in the following zip code areas: 53005, 53006, 53012, 53017, 53022, 53024, 53027, 53029, 53033, 53036, 53037, 53040, 53042, 53045, 43046, 53051, 53066, 53072, 53074, 53080, 53086, 53089, 53092, 53094, 53095, 53097, 53098, 53099, 53103, 53104, 53105, 53110, 53120, 53121, 53132, 53139, 53140, 53142, 53144, 53150, 53151, 53154, 53172, 53177, 53179, 53182, 53186, 53188, 53192, 53202, 53207, 53208, 53209, 53210, 53211, 53212, 53213, 53214, 53215, 53216, 53218, 53219, 53220, 53221, 53222, 53223, 53224, 53225, 53226, 53227, 53228, 53402, 53403, 53405, 53406, 53523, 53538, 53545, 53546, 53551, 53559, 53562, 53590, 53593, 53594, 53711, 53719, 53901, 53913, 53915, 53925, 53946, 53948, 53951, 53956, 54028, 54110, 54113, 54115, 54130, 54170, 54201, 54220, 54227, 54228, 54241, 54304, 54354, 54401, 54452, 54455, 54456, 54463, 54476, 54481, 54494, 54501, 54520, 54548, 54601, 54629, 54637, 54650, 54656, 54658, 54669, 54701, 54703, 54729, 54751, 54901, 54911, 54913, 54914, 54915, 54935, 54937, 54942, 54956, 54969, 54971, 54983

Plan Benefits

We will pay benefits for covered dental expenses listed under Copayment Amounts in this Schedule of Benefits and the Type IV Orthodontic Dental Services provision of your certificate or the *policy*. The services listed under Copayment Amounts and in the Type IV Orthodontic Dental Services provision are a complete list of covered dental services whether performed by a *preferred provider* or a *non-preferred provider*. Any service not specifically listed under Copayment Amounts and the Type IV Orthodontic Dental Services provision is not a covered dental service. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in this Schedule of Benefits. However, benefits will be payable based on the most current dental terminology. This Schedule of Benefits may be updated periodically upon written notice.

Before we will pay benefits, you or a *covered dependent*, as applicable, must satisfy any deductible required for the *policy year*, as well as any applicable waiting periods. Benefits are subject to all applicable benefit maximums.

Services Performed by Preferred Providers

For covered dental services performed by a *preferred provider* (other than Type IV Orthodontic Dental Services), you will be responsible for the applicable amount shown under Copayment Amounts. *Copayments* in the column titled "Preferred Provider Specialist – Your Copayment" apply to services performed by a *preferred provider* specialist of Oral Surgery, Endodontics, Periodontics, Pediatric Dentistry or Prosthodontics. We will be responsible for the payment of any remaining charges for covered dental services performed by a *preferred provider*. For Type IV Orthodontic Dental Services performed by a *preferred provider*, we will pay the coinsurance percentage shown under Coinsurance Percentage – Preferred Provider Plan. After we have paid any applicable coinsurance percentage for Type IV Orthodontic Dental Services, you will be responsible for any remaining charges.

Services Performed by Non-Preferred Providers

For covered dental services performed by a *non-preferred provider*, including any Type IV Orthodontic Dental Services, we will pay the applicable coinsurance percentage shown under Coinsurance

SCHEDULE OF BENEFITS (continued)

Percentages – Non-Preferred Provider Plan. After we have paid any applicable coinsurance percentage for a covered dental expense, you will be responsible for any remaining charges.

The rights and benefits described in this Schedule of Benefits are subject to the terms, provisions, limitations and exclusions contained in this Schedule of Benefits and in the *policy* and certificate. Please read your certificate carefully.

SCHEDULE OF BENEFITS (continued)

Deductible Amount	Preferred Provider Plan (In-Network Plan)	Non-Preferred Provider Plan (Out-of-Network Plan)
Individual Deductible Amount:	\$0	\$50
Waived for Preventive:	Yes	No
Individual Deductible Amount for Type IV Orthodontic Services:	\$0	\$0
Maximum Family Deductible:	Does Not Apply	3 persons individually

The Family Deductible does not apply to Type IV Orthodontic Services.

Coinsurance Percentages

Type I Services:	See Copayment Amounts	80%
Type II Services:	See Copayment Amounts	60%
Type III Services:	See Copayment Amounts	40%
Type IV Orthodontic Services:	50%	50%

Benefit Maximums

<i>Policy Year</i> Maximum:	\$1,000	\$750
Overall Benefit Maximums:		
Type IV Orthodontic Services:	\$1,000	\$750

Amounts applied to the benefit maximums will apply to both the Preferred Provider Plan and Non-Preferred Provider Plan maximums.

Discounts on dental care products are available. Please visit the For Members site at www.assurantemployeebenefits.com for details.

Waiting Periods

There are waiting periods which must be fulfilled before benefits will be payable for specified dental services. The waiting periods for Type III and Type IV dental services for timely applicants are shown below. Separate waiting periods may apply to late applicants. Please see the Special Limitations provisions in the *policy* and certificate.

Type III Services:	12 months	12 months
Type IV Orthodontic Services:	12 months	12 months

Plan Changes

You may change your plan of insurance only during December 1 through December 31 of each year, the annual enrollment period agreed upon by the *policyholder* and us, unless you undergo a change in family status. A plan change made during the annual enrollment period will take effect on the next following policy anniversary.

You may change your plan within 31 days of a change in family status. The effective date of the change will be the Entry Date occurring on or after the date of the request.

A "change in family status" means your marriage or divorce, the birth or adoption of your child, the death of your spouse or child, the termination of employment of your spouse.

The "Waiting Period for Insured Persons Generally" provision will apply to changes made during an annual enrollment period and changes made due to change in family status.

SCHEDULE OF BENEFITS (continued)

Copayment Amounts – Preferred Provider Plan (In-Network Plan)

The *copayment* amounts for Type I, II, and III covered dental services performed by a *preferred provider* are listed below.

The *copayment* amounts below are for use beginning on January 1, 2008.

Effective On: 01/01/2008		Preferred Provider	Preferred Provider
ADA		General Dentist	Specialist
Code**	Service Description**	Your Copayment	Your Copayment
Type I - Preventive Services			
Clinical Oral Evaluations			
(one evaluation will be covered in a 6-month period)			
D0120	Periodic oral evaluation	No charge.....	No charge
D0140	Limited oral evaluation - problem focused	No charge.....	No charge
D0150	Comprehensive oral evaluation - new or established patient.....	No charge.....	No charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No charge.....	No charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge.....	No charge
D0180	Comprehensive periodontal evaluation - new or established patient.....	No charge.....	No charge
Radiographs/Diagnostic Imaging (includes interpretation)			
D0210	Intraoral - complete series (including bitewings)	10.00.....	15.00
(limited to one time in a 60-month period)			
D0220	Intraoral - periapical first film*	No charge.....	5.00
D0230	Intraoral - periapical each additional film*	No charge.....	5.00
(*Codes D0220, D0230 no more than 4 periapical films in any 12-month period)			
D0240	Intraoral - occlusal film	No charge.....	5.00
(limited to 2 occlusal films in any 6-month period)			
D0250	Extraoral - first film*	No charge.....	5.00
D0260	Extraoral - each additional film*	No charge.....	5.00
(*Codes D0250, D0260 no more than 2 films in any 12-month period)			
D0270	Bitewing - single film*	No charge.....	5.00
D0272	Bitewings - two films*	No charge.....	5.00
D0274	Bitewings - four films*	No charge.....	5.00
(*Codes D0270, D0272, D0274 no more than 2 or 4 bitewing films in any 12-month period)			
D0277	Vertical bitewings - 7 to 8 films	10.00.....	15.00
(once in any 36-month period)			
D0330	Panoramic film.....	10.00.....	15.00
(one panoramic film or one complete intraoral series in a 60-month period - see D0210)			
Test and Examination			
D0415	Collection of microorganisms for culture and sensitivity	10.00.....	15.00
Preventive			
D1110	Prophylaxis - adult.....	5.00.....	10.00
(Once in any 6-month period, frequency combined with periodontal maintenance procedure code D4910. Total number of combined prophylaxis services and periodontal maintenance procedures not to exceed 4 in a 12-month period.)			
D1120	Prophylaxis - child*	5.00.....	10.00
(once in any 6-month period)			
D1203	Topical application of fluoride (prophylaxis not included) - child*	5.00.....	5.00
D1351	Sealant - per tooth*	5.00.....	10.00
(permanent molar - once in any 36-month period)			
(*Codes D1120, D1203, D1351 child to age 14)			
Space Maintainers (Passive Appliances)			
(Includes all adjustments and recementations made within 6 months of seating)			

SCHEDULE OF BENEFITS (continued)

Effective On: 01/01/2008		Preferred Provider	Preferred Provider
ADA Code**	Service Description**	General Dentist Your Copayment	Specialist Your Copayment
D1510	Space maintainer - fixed - unilateral*	20.00	25.00
D1515	Space maintainer - fixed - bilateral*	30.00	35.00
D1525	Space maintainer - removable - bilateral*	35.00	40.00
D1550	Re-cementation of space maintainer	5.00	10.00
(*Codes D1510, D1515, D1525 to age 16)			
Professional Consultation			
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	10.00	15.00

Type II - Basic Services

Restorative

Fees for a restoration include adhesives, etching, liners, bases, direct or indirect pulp cap and local anesthesia. Replacement frequency is one time in any 36-month period. Multiple restorations on one surface are deemed to be a single restoration for benefit purposes.

Amalgam Restorations (including polishing)

D2140	Amalgam - one surface, primary or permanent.....	25.00	30.00
D2150	Amalgam - two surfaces, primary or permanent.....	30.00	35.00
D2160	Amalgam - three surfaces, primary or permanent.....	35.00	40.00
D2161	Amalgam - four or more surfaces, primary or permanent.....	40.00	45.00

Resin-Based Composite Restorations - Direct

D2330	Resin-based composite - one surface, anterior	30.00	35.00
D2331	Resin-based composite - two surfaces, anterior	35.00	40.00
D2332	Resin-based composite - three surfaces, anterior	40.00	45.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	50.00	55.00
D2391	Resin-based composite - one surface, posterior	40.00	45.00
D2392	Resin-based composite - two surfaces, posterior	50.00	55.00
D2393	Resin-based composite - three surfaces, posterior	60.00	65.00
D2394	Resin-based composite - four or more surfaces, posterior	70.00	75.00

Non-Restorative

Extractions

(Includes local anesthesia, suturing, if needed, and routine post-operative care)

D7111	Extraction, coronal remnants - deciduous tooth	20.00	25.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	30.00	35.00

Surgical Incision

D7510	Incision and drainage of abscess - intraoral soft tissue.....	35.00	40.00
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Unclassified Treatment

D9110	Palliative (emergency) treatment of dental pain - minor procedure	20.00	25.00
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Type III - Major Services

(check schedule of benefits for any applicable waiting periods)

Restorative

Fees include pulp capping, laboratory costs, temporary restorations, cement bases, liners, local anesthesia, gingival tissue preparation and one-year follow-up care. Codes listed from D2510 to D2794 are limited to persons over age 16 with a 10-year replacement frequency.

Inlay/Onlay Restorations

D2510	Inlay - metallic - one surface	200.00	210.00
D2520	Inlay - metallic - two surfaces.....	250.00	265.00
D2530	Inlay - metallic - three or more surfaces	275.00	290.00
D2542	Onlay - metallic - two surfaces.....	275.00	290.00
D2543	Onlay - metallic - three surfaces	300.00	315.00
D2544	Onlay - metallic - four or more surfaces.....	335.00	355.00
D2610	Inlay - porcelain/ceramic one surface	250.00	265.00

SCHEDULE OF BENEFITS (continued)

Effective On: 01/01/2008		Preferred Provider	Preferred Provider
ADA		General Dentist	Specialist
Code**	Service Description**	Your Copayment	Your Copayment
D2620	Inlay - porcelain/ceramic two surfaces	275.00	290.00
D2630	Inlay - porcelain/ceramic three or more surfaces	300.00	315.00
D2642	Onlay - porcelain/ceramic two surfaces	275.00	290.00
D2643	Onlay - porcelain/ceramic three surfaces	300.00	315.00
D2644	Onlay - porcelain/ceramic four or more surfaces	335.00	355.00
Crowns - Single Restorations Only			
D2740	Crown - porcelain/ceramic substrate	370.00	390.00
D2750	Crown - porcelain fused to high noble metal	370.00	390.00
D2751	Crown - porcelain fused to predominantly base metal	300.00	315.00
D2752	Crown - porcelain fused to noble metal	335.00	355.00
D2780	Crown - 3/4 cast high noble metal	335.00	355.00
D2781	Crown - 3/4 cast predominantly base metal	275.00	290.00
D2782	Crown - 3/4 cast noble metal	300.00	315.00
D2783	Crown - 3/4 porcelain/ceramic	335.00	355.00
	(does not include facial veneers)		
D2790	Crown - full cast high noble metal	370.00	390.00
D2791	Crown - full cast predominantly base metal	300.00	315.00
D2792	Crown - full cast noble metal	335.00	355.00
D2794	Crown - titanium	370.00	390.00
Other Restorative Services			
D2910	Recement inlay, onlay, or partial coverage restoration	30.00	35.00
D2920	Recement crown	30.00	35.00
D2930	Prefabricated stainless steel crown - primary tooth	80.00	85.00
D2931	Prefabricated stainless steel crown - permanent tooth	80.00	85.00
	(*Codes D2930, D2931 to age 16, 1 time in any 36-month period)		
D2940	Sedative filling	25.00	30.00
	(covered but not in conjunction with restorative services)		
D2950	Core buildup, including any pins	70.00	75.00
D2951	Pin retention - per tooth, in addition to restoration	15.00	20.00
D2952	Cast post and core in addition to crown	100.00	105.00
D2954	Prefabricated post and core in addition to crown	90.00	95.00
D2971	Additional procedures to construct new crown under existing partial denture framework	50.00	55.00
D2980	Crown repair, by report	70.00	75.00
	(covered after 12 months have passed since initial insertion)		
Endodontic Services			
	Root canal therapy, including all operative and post-operative X-rays, bacteriologic cultures, local anesthesia and routine follow-up care, limited to one time on the same tooth in any 24-month period.		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinoenamel junction and application of medicament	50.00	55.00
D3310	Anterior (excluding final restoration)	200.00	210.00
D3320	Bicuspid (excluding final restoration)	250.00	265.00
D3330	Molar (excluding final restoration)	335.00	355.00
D3346	Retreatment of previous root canal therapy - anterior	275.00	290.00
D3347	Retreatment of previous root canal therapy - bicuspid	300.00	315.00
D3348	Retreatment of previous root canal therapy - molar	370.00	390.00
D3351	Apexification/recalcification - initial visit (apical closure/calific repair of perforations, root resorption, etc.)	80.00	85.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calific repair of perforations, root resorption, etc.)	40.00	45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.)	145.00	155.00

SCHEDULE OF BENEFITS (continued)

Effective On: 01/01/2008		Preferred Provider General Dentist Your Copayment	Preferred Provider Specialist Your Copayment
ADA Code**	Service Description**		
D3410	Apicoectomy/periradicular surgery - anterior	200.00	210.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	225.00	240.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	250.00	265.00
D3426	Apicoectomy/periradicular surgery - (each additional root)	80.00	85.00
D3430	Retrograde filling - per root	70.00	75.00
D3920	Hemisection (including any root removal), not including root canal therapy	100.00	105.00
D3950	Canal preparation and fitting of preformed dowel or post	40.00	45.00
Periodontic Services			
Codes listed D4210, D4211, D4240, D4241, D4260 and D4261 covered only if more than 36 months have passed since any previous gingivectomy, flap procedure or osseous surgery was performed in the same area of the mouth.			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	160.00	170.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	50.00	55.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	200.00	210.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	115.00	125.00
D4249	Clinical crown lengthening - hard tissue	250.00	265.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	335.00	355.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	180.00	190.00
D4263	Bone replacement graft - first site in quadrant	130.00	140.00
D4264	Bone replacement graft - each additional site in quadrant	100.00	105.00
D4271	Free soft tissue graft procedure (including donor site surgery)	275.00	290.00
Non-Surgical Periodontal Services			
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	80.00	85.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	35.00	40.00
(*Codes D4341, D4342 once in any 24-month period)			
Other Periodontal Services			
D4910	Periodontal maintenance	40.00	45.00
(Once in any 3-month period, frequency combined with dental prophylaxis services code D1110. Total number of combined periodontal maintenance procedures and dental prophylaxis services not to exceed 4 in a 12-month period. Service is deemed to include scaling, root planing and polishing of teeth.)			
Prosthodontic (Removable) Services			
Complete and partial dentures limited to one time per arch unless 10 years have elapsed since last replacement and the denture cannot be made serviceable. Complete and partial dentures are deemed to include local anesthesia, and one-year follow-up care. Partial dentures are deemed to include all replacement teeth, all clasps and rests.			
D5110	Complete denture - maxillary	435.00	455.00
D5120	Complete denture - mandibular	435.00	455.00
D5130	Immediate denture - maxillary	470.00	495.00
D5140	Immediate denture - mandibular	470.00	495.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	335.00	355.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	335.00	355.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	435.00	455.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	435.00	455.00

SCHEDULE OF BENEFITS (continued)

Effective On: 01/01/2008		Preferred Provider General Dentist Your Copayment	Preferred Provider Specialist Your Copayment
ADA Code**	Service Description**		
D5225	Maxillary partial denture - flexible base (including any conventional clasps, rests and teeth)	400.00	420.00
D5226	Mandibular partial denture - flexible base (including any conventional clasps, rests and teeth)	400.00	420.00
Adjustment To Dentures			
Adjustments or repairs to complete and partial dentures are covered only if 12 months have passed since the initial insertion. Relining of dentures and tissue conditioning covered no more than one time in any 36-month period and only if more than 12 months have passed since the initial insertion. Adjustments are also limited to one time in any 12-month period.			
D5410	Adjust complete denture - maxillary.....	15.00	20.00
D5411	Adjust complete denture - mandibular	15.00	20.00
D5421	Adjust partial denture - maxillary.....	15.00	20.00
D5422	Adjust partial denture - mandibular	15.00	20.00
Repairs to Complete Dentures			
D5510	Repair broken complete denture base	50.00	55.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	40.00	45.00
Repairs to Partial Dentures			
D5610	Repair resin denture base.....	40.00	45.00
D5620	Repair cast framework	50.00	55.00
D5630	Repair or replace broken clasp	50.00	55.00
D5640	Replace broken teeth - per tooth	40.00	45.00
D5650	Add tooth to existing partial denture	60.00	65.00
D5660	Add clasp to existing partial denture.....	50.00	55.00
Denture Reline Procedures			
D5730	Reline complete maxillary denture (chairside).....	80.00	85.00
D5731	Reline complete mandibular denture (chairside).....	80.00	85.00
D5740	Reline maxillary partial denture (chairside).....	80.00	85.00
D5741	Reline mandibular partial denture (chairside).....	80.00	85.00
D5750	Reline complete maxillary denture (laboratory).....	115.00	125.00
D5751	Reline complete mandibular denture (laboratory).....	115.00	125.00
D5760	Reline maxillary partial denture (laboratory).....	115.00	125.00
D5761	Reline mandibular partial denture (laboratory).....	115.00	125.00
Interim Prosthesis			
D5820	Interim partial denture (maxillary)	160.00	170.00
D5821	Interim partial denture (mandibular).....	160.00	170.00
Other Removable Prosthetic Services			
D5850	Tissue conditioning, maxillary.....	40.00	45.00
D5851	Tissue conditioning, mandibular	40.00	45.00
Implant Services			
Codes listed D6010, D6053-6079, D6094 and D6194 limited to persons over age 16 with a 10-year replacement frequency.			
D6010	Surgical placement of implant body: endosteal implant.....	570.00	600.00
D6053	Implant/abutment supported removable denture for completely edentulous arch	470.00	495.00
D6054	Implant/abutment supported removable denture for partially edentulous arch	470.00	495.00
D6058	Abutment supported porcelain/ceramic crown	370.00	390.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	370.00	390.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	300.00	315.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	335.00	355.00
D6062	Abutment supported cast metal crown (high noble metal)	370.00	390.00
D6063	Abutment supported cast metal crown (predominantly base metal)	300.00	315.00
D6064	Abutment supported cast metal crown (noble metal)	335.00	355.00
D6094	Abutment supported crown - (titanium)	370.00	390.00

SCHEDULE OF BENEFITS (continued)

Effective On: 01/01/2008		Preferred Provider General Dentist Your Copayment	Preferred Provider Specialist Your Copayment
ADA Code**	Service Description**		
D6065	Implant supported porcelain/ceramic crown	370.00	390.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	370.00	390.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	370.00	390.00
D6068	Abutment supported retainer for porcelain/ceramic FPD	370.00	390.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	370.00	390.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	300.00	315.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	335.00	355.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	370.00	390.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	300.00	315.00
D6074	Abutment supported retainer for cast metal FPD (noble metal)	335.00	355.00
D6194	Abutment supported retainer crown for FPD - (titanium)	370.00	390.00
D6075	Implant supported retainer for ceramic FPD	370.00	390.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	370.00	390.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	370.00	390.00
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis..... (once every 6 months)	40.00	45.00
Prostodontics, Fixed Services			
Codes listed from D6210 to D6794 fixed partial dentures limited to persons over age 16 with replacement frequency of 10 years. Fees include direct or indirect pulp cap, laboratory costs, temporary restorations, cement bases, liners, local anesthesia, gingival tissue preparation, and one-year follow-up care.			
Fixed Partial Denture Pontics			
D6210	Pontic - cast high noble metal.....	335.00	355.00
D6211	Pontic - cast predominantly base metal.....	275.00	290.00
D6212	Pontic - cast noble metal.....	300.00	315.00
D6214	Pontic - titanium.....	335.00	355.00
D6240	Pontic - porcelain fused to high noble metal.....	335.00	355.00
D6241	Pontic - porcelain fused to predominantly base metal.....	275.00	290.00
D6242	Pontic - porcelain fused to noble metal.....	300.00	315.00
D6245	Pontic - porcelain/ceramic.....	335.00	355.00
Fixed Partial Denture Retainers - Crowns			
D6740	Crown - porcelain/ceramic	370.00	390.00
D6750	Crown - porcelain fused to high noble metal	370.00	390.00
D6751	Crown - porcelain fused to predominantly base metal	300.00	315.00
D6752	Crown - porcelain fused to noble metal	335.00	355.00
D6780	Crown - 3/4 cast high noble metal	335.00	355.00
D6781	Crown - 3/4 cast predominantly base metal	275.00	290.00
D6782	Crown - 3/4 cast noble metal	300.00	315.00
D6790	Crown - full cast high noble metal.....	370.00	390.00
D6791	Crown - full cast predominantly base metal.....	300.00	315.00
D6792	Crown - full cast noble metal.....	335.00	355.00
D6794	Crown - titanium.....	370.00	390.00
Other Fixed Partial Denture Services			
D6930	Recement fixed partial denture	40.00	45.00
D6970	Cast post and core in addition to fixed partial denture retainer.....	100.00	105.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.....	90.00	95.00
D6973	Core build up for retainer, including any pins	70.00	75.00

SCHEDULE OF BENEFITS (continued)

Effective On: 01/01/2008		Preferred Provider General Dentist Your Copayment	Preferred Provider Specialist Your Copayment
ADA Code**	Service Description**		
D6980	Fixed partial denture repair, by report.....	70.00	75.00
Surgical Extractions			
(Includes local anesthesia, suturing, if needed and routine postoperative care)			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	80.00	85.00
D7220	Removal of impacted tooth - soft tissue.....	90.00	95.00
D7230	Removal of impacted tooth - partially bony.....	115.00	125.00
D7240	Removal of impacted tooth - completely bony.....	130.00	140.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.....	145.00	155.00
D7250	Surgical removal of residual tooth roots (cutting procedure).....	80.00	95.00
Other Surgical Procedures			
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	180.00	190.00
D7285	Biopsy of oral tissue - hard (bone, tooth).....	115.00	125.00
D7286	Biopsy of oral tissue - soft..... (surgical removal of an architecturally intact specimen only)	90.00	95.00
Alveoplasty - Surgical Preparation of Ridge For Dentures			
D7310	Alveoplasty in conjunction with extractions - per quadrant.....	80.00	85.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	50.00	55.00
D7320	Alveoplasty not in conjunction with extractions - per quadrant.....	160.00	170.00
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.....	100.00	105.00
Excision of Bone Tissue			
D7471	Removal of lateral exostosis (maxilla or mandible).....	145.00	155.00
D7472	Removal of torus palatinus	145.00	155.00
D7473	Removal of torus mandibularis	145.00	155.00
Other Repair Procedures			
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.....	145.00	155.00
D7971	Excision of pericoronal gingiva	50.00	55.00
Anesthesia			
Anesthesia is considered a separate covered dental service and covered only when medically necessary for a covered complex oral surgery service.			
D9220	Deep sedation/general anesthesia - first 30 minutes	130.00	140.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.....	40.00	45.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	100.00	105.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	40.00	45.00
Drugs			
D9610	Therapeutic drug injection, by report	10.00	15.00

**Current Dental Terminology © American Dental Association.