KAISER PERMANENTE®

IMPORTANT NOTICE

KAISER PERMANENTE COLORADO BRIDGE PROGRAM

Schedule of Benefits for the Denver/Boulder, Northern Colorado and Pueblo Service Areas

The Kaiser Permanente Colorado Bridge Program is designed to help those who are uninsured with no access to other health coverage pay for standard Kaiser Permanente Individuals and Families (KPIF) plan (KP CO Gold 0/20). The Colorado Bridge Program also includes the Kaiser Permanente sponsored medical financial assistance program, Medical Financial Assistance (MFA) that eliminates out-of-pocket costs for most services provided at Kaiser Permanente medical offices. Under the Colorado Bridge Program, monthly premiums for the KP CO Gold 0/20 plan start at $20 for one person and $60 for a family, based on family size and income (premiums are subject to change). MFA lowers the cost sharing for services provided at Kaiser Permanente medical offices to $0. For services not provided at Kaiser Permanente medical offices, members are responsible for the full cost sharing under the KP CO 0/20 plan. The coverage period lasts up to 24 months but not beyond December 31 of the calendar year, with an opportunity to renew. If you do not send in your monthly payments, your KP CO Gold 0/20 coverage, including MFA, will end and you will not be eligible to re-apply until the next open enrollment period.

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this Membership Agreement. For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this Membership Agreement in conjunction with this Schedule of Benefits. Please refer to the heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this Membership Agreement.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

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Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the "Definitions" section in this Membership Agreement); and
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; and
   c. The Service must be described in this Membership Agreement as covered. Refer to the "Benefits/Coverage (What is Covered)" section.
2. The Charges for your Services are not always known at the time you receive the Service. You will get a bill for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the OPM. Non-covered Services will not apply to the OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. In addition to any Copayment or Coinsurance, you may be responsible for any amounts over usual, reasonable and customary charges.
6. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
7. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
8. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
9. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.
10. The family Deductible and OPM amounts are applicable for a newborn child, even if the newborn is covered only for the first 31 days that is required by state law.
11. Day and visit limits, Deductibles, and OPMs are based on a calendar year Accumulation Period.

I. DEDUCTIBLES

There is no medical Deductible. If the plan purchased has a prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan purchased.

A. For prescription drugs that ARE subject to the pharmacy Deductible:

1. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Prescription Drugs, Supplies and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.
2. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Prescription Drugs, Supplies and Supplements").
3. Your applicable Deductible, Copayment, Coinsurance, and pharmacy Deductible apply to your annual OPM (see "II. Annual Out-of-Pocket Maximums").

B. For prescription drugs that ARE NOT subject to the pharmacy Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance", "Prescription Drugs, Supplies and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan purchased.

For covered Services that apply to the OPM, any amounts over usual, reasonable and customary charges will not apply toward the OPM.

A. For covered Services that APPLY to the OPM:

1. The only Copayments or Coinsurance that apply toward the OPM are those made for covered Services listed as applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will no longer pay for covered Services that apply to the OPM for the rest of the Accumulation Period.

B. For covered Services that do NOT APPLY to the OPM:

1. The only Copayments or Coinsurance that do not apply toward the OPM are those made for covered Services listed as not applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that do not apply to the OPM for the rest of the Accumulation Period.

Tracking Pharmacy Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will send you an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your pharmacy Deductible and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call Member Services.

Benefits for KP CO Gold 0/20

III. COPAYMENTS AND COINSURANCE

OUT-OF-POCKET MAXIMUM	
Embedded An Embedded OPM means: • Each individual family Member has his or her own OPM. • If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.	$6,550/Individual per Accumulation Period $13,100/Family per Accumulation Period

OFFICE SERVICES	YOU PAY
Primary care visits (Applies to Out-of-Pocket Maximum)	$20 Copayment each visit
Specialty care visits (Applies to Out-of-Pocket Maximum)	$40 Copayment each visit
Consultations with clinical pharmacists (Applies to Out-of-Pocket Maximum)	$20 Copayment each visit
Allergy evaluation and testing (Applies to Out-of-Pocket Maximum)	$40 Copayment each visit
Allergy injections (Applies to Out-of-Pocket Maximum)	$20 Copayment each visit Copayment may apply for allergy serum
Gynecology care visits (Applies to Out-of-Pocket Maximum)	$40 Copayment each visit
Routine prenatal and postpartum visits (Applies to Out-of-Pocket Maximum)	35% Coinsurance
Office administered drugs (Applies to Out-of-Pocket Maximum) • Travel immunizations *(Does not apply to Out-of-Pocket Maximum)*	$500 Copayment per drug Not covered
Telemedicine • Email (Applies to Out-of-Pocket Maximum) • Online (Applies to Out-of-Pocket Maximum) • Telephone (Applies to Out-of-Pocket Maximum) • Video visits ○ Primary care visits (Applies to Out-of-Pocket Maximum) ○ Specialty care visits (Applies to Out-of-Pocket Maximum)	 No Charge No Charge No Charge $20 Copayment each visit $40 Copayment each visit

OUTPATIENT HOSPITAL AND SURGICAL SERVICES	YOU PAY
Outpatient surgery at Plan Facilities (Applies to Out-of-Pocket Maximum)	35% Coinsurance
Outpatient hospital Services (Applies to Out-of-Pocket Maximum)	35% Coinsurance

HOSPITAL INPATIENT CARE	YOU PAY
(See "Hospital Inpatient Care" in "Benefits/Coverage (What is Covered)" for the list of covered Services.) (Applies to Out-of-Pocket Maximum)	35% Coinsurance
Inpatient professional Services (See above line under "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)	See above line under "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

ALTERNATIVE MEDICINE	YOU PAY
Chiropractic Care • Evaluation and/or Manipulation (Applies to Out-of-Pocket Maximum) • Laboratory Services or X-rays required for Chiropractic Care (See "X-ray, Laboratory, and X-ray Special Procedures" for Out-of-Pocket Maximum information.)	$20 Copayment each visit Limited to 20 visits per Accumulation Period See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services (Does not apply to Out-of-Pocket Maximum)	Not Covered

AMBULANCE SERVICES	**YOU PAY**
(Applies to Out-of-Pocket Maximum)	35% Coinsurance

BARIATRIC SURGERY	**YOU PAY**
(Applies to Out-of-Pocket Maximum)	35% Coinsurance

CHEMICAL DEPENDENCY SERVICES	YOU PAY
Inpatient medical detoxification (Applies to Out-of-Pocket Maximum)	35% Coinsurance
Inpatient professional Services for medical detoxification (See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for Out-of-Pocket Maximum information.)	See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for applicable Copayment or Coinsurance.
Outpatient individual therapy (Applies to Out-of-Pocket Maximum)	$20 Copayment each visit; $20 Copayment per partial hospitalization day
Outpatient group therapy (Applies to Out-of-Pocket Maximum)	50% of individual therapy Copayment
Residential rehabilitation (Applies to Out-of-Pocket Maximum)	35% Coinsurance

DENTAL SERVICES	
Members age 19 and over	Not Covered
Pediatric Dental Services • Limited to members up to the end of the month he/she turns age 19	See end of Section III.

DIALYSIS CARE	YOU PAY
(Applies to Out-of-Pocket Maximum)	$40 Copayment each visit

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS AND ORTHOTICS	YOU PAY
Durable medical equipment (Applies to Out-of-Pocket Maximum) • Breast pumps (Applies to Out-of-Pocket Maximum)	35% Coinsurance No Charge
Prosthetic devices • Internally implanted prosthetic devices (See "Outpatient Hospital and Surgical Services" and "Hospital Inpatient Care" for Out-of-Pocket Maximum information.) • Prosthetic arm or leg (Applies to Out-of-Pocket Maximum) • All other prosthetic devices (Applies to Out-of-Pocket Maximum)	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance. 20% Coinsurance 35% Coinsurance
Orthotic devices (Applies to Out-of-Pocket Maximum)	35% Coinsurance
Oxygen (Applies to Out-of-Pocket Maximum)	35% Coinsurance

EMERGENCY SERVICES	YOU PAY
Plan and non-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) (Applies to Out-of-Pocket Maximum)	$500 Copayment each visit. Excludes X-ray special procedures* Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. *If X-ray special procedures are excluded, see "X-ray, Laboratory and Special Procedures" for applicable Copayment or Coinsurance.

URGENT CARE	YOU PAY
Plan Facility within Service Area (Applies to Out-of-Pocket Maximum)	$75 Copayment each visit
Urgent care Services outside Service Area (Applies to Out-of-Pocket Maximum) Covered only if all the following requirements are met: • The care is required to prevent serious decline of health • The need for care results from an unforeseen illness or injury when temporarily away from our Service Area • The care cannot be delayed until you return to our Service Area.	$75 Copayment each visit

FAMILY PLANNING SERVICES	**YOU PAY**
Family planning counseling (See "Office Services" for Out-of-Pocket Maximum information)	See "Office Services" for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures (See "Outpatient Hospital and Surgical Services" for Out-of-Pocket Maximum information.)	See "Outpatient Hospital and Surgical Services" for applicable Copayment or Coinsurance.

HEALTH EDUCATION SERVICES	**YOU PAY**
Training in self-care and preventive care (See "Office Services" for Out-of-Pocket Maximum information)	See "Office Services" for applicable Copayment or Coinsurance.

HEARING SERVICES	YOU PAY
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist (Applies to Out-of-Pocket Maximum)	$20 Copayment each visit
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist (Applies to Out-of-Pocket Maximum)	$40 Copayment each visit
Hearing aids for Members under the age of 18 (Applies to Out-of-Pocket Maximum) • Fitting and Recheck visits (Applies to Out-of-Pocket Maximum)	$20 Copayment each visit $20 Copayment each visit
Hearing aids for Members age 18 and over (Does not apply to Out-of-Pocket Maximum) • Fitting and Recheck visits (Does not apply to Out-of-Pocket Maximum)	Not Covered Not Covered

HOME HEALTH CARE	YOU PAY
Home health Services provided by a Plan Physician (Applies to Out-of-Pocket Maximum)	No Charge

HOSPICE CARE	YOU PAY
Special Services program for hospice-eligible Members who have not yet elected hospice care (Applies to Out-of-Pocket Maximum)	No Charge
Hospice care for terminally ill patients (Applies to Out-of-Pocket Maximum)	No Charge

INFERTILITY SERVICES	YOU PAY
Covered Services for diagnosis and treatment of infertility (Applies to Out-of-Pocket Maximum)	35% Coinsurance
Intrauterine insemination, including associated X-ray and laboratory Services (Applies to Out-of-Pocket Maximum)	35% Coinsurance

MENTAL HEALTH SERVICES	YOU PAY
Inpatient psychiatric hospitalization (Applies to Out-of-Pocket Maximum)	35% Coinsurance
Inpatient professional Services for psychiatric hospitalization (See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for Out-of-Pocket Maximum information)	See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for applicable Copayment or Coinsurance
Outpatient individual therapy (Applies to Out-of-Pocket Maximum)	$20 Copayment each visit $20 Copayment per partial hospitalization day
Outpatient group therapy (Applies to Out-of-Pocket Maximum)	50% of individual therapy Copayment

OUT-OF-AREA BENEFIT	YOU PAY
The following Services are limited to Dependents up to the age of 26 living outside the Service Area	
Outpatient office visits (Combined visit limit between primary care, specialty care, outpatient mental health and chemical dependency, gynecology care, preventive care, and a visit with the administration of allergy injections. Office visits do not include: allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, pediatric dental, hearing exams, home health visits, hospice services, immunizations, and applied behavioral analysis (ABA).) Visit: (Applies to Out-of-Pocket Maximum) Other Services: (Do not apply to Out-of-Pocket Maximum)	Visit: $20 Copayment each visit Other Services received during an office visit: Not Covered Limited to 5 visits per Accumulation Period
Diagnostic X-ray Services (Applies to Out-of-Pocket Maximum)	20% Coinsurance Limited to 5 diagnostic X-rays per Accumulation Period
Outpatient physical, occupational, and speech therapy visits (Applies to Out-of-Pocket Maximum)	Visit: $20 Copayment each visit Limited to 5 therapy visits (any combination) per Accumulation Period
Outpatient Prescription Drugs (Not subject to pharmacy Deductible; Prescriptions: Apply to Out-of-Pocket Maximum)	See "Prescription Drugs, Supplies and Supplements" for applicable Copayment or Coinsurance. Limited to 5 prescription drug fills per Accumulation Period

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY AND MULTIDISCIPLINARY REHABILITATION SERVICES	YOU PAY
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility (Applies to Out-of-Pocket Maximum)	35% Coinsurance Up to 60 days per condition per Accumulation Period.
Short-term outpatient physical, occupational, and speech therapy visits (Applies to Out-of-Pocket Maximum) • Habilitative Services • Rehabilitative Services Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder (Applies to Out-of-Pocket Maximum)	$30 Copayment each visit Limited to 20 visits per therapy per Accumulation Period Limited to 20 visits per therapy per Accumulation Period $30 Copayment each visit
Applied Behavioral Services • Applied Behavior Analysis (ABA) (Applies to Out-of-Pocket Maximum)	$20 Copayment each visit
Pulmonary rehabilitation (Applies to Out-of-Pocket Maximum)	$30 Copayment each visit

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PRESCRIPTION DRUGS, SUPPLIES, AND SUPPLEMENTS	YOU PAY
Outpatient prescription drugs (Do apply to Out-of-Pocket Maximum)	
• Pharmacy Deductible	Not Applicable
• Copayment/Coinsurance (except as listed below):	$10 Generic/$30 Brand name $150 Non-Preferred *For Southern Colorado Members:* *Prescriptions for second and ongoing maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order.*
• Specialty Drugs	$500 each retail prescription; $1,000 each mail order prescription Insulin at applicable Copayment
• Infertility drugs (Does not apply to Out-of-Pocket Maximum)	Not Covered
• Prescribed supplies (When obtained from sources designated by Kaiser Permanente)	20% Coinsurance
• Over the counter items (OTC): (Includes federally mandated over the counter items (OTC). OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)	No Charge
• Tobacco cessation drugs	No Charge
• Sexual dysfunction drugs (Does not apply to Out-of-Pocket Maximum)	Not Covered
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$20 Generic/$60 Brand name/$300 Non-Preferred Up to 90 days

PREVENTIVE CARE SERVICES	YOU PAY
Preventive care visits (Applies to Out-of-Pocket Maximum) • Adult preventive care exams and screenings • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge
Colorectal cancer screenings (Applies to Out-of-Pocket Maximum) • Colonoscopies • Flexible sigmoidoscopies	 No Charge No Charge
Non-preventive covered Services received in conjunction with preventive care exam (See "Office Services" or "Diagnostic Laboratory Services" for Out-of-Pocket Maximum information.)	See "Office Services" or "Diagnostic Laboratory Services" for applicable Copayment or Coinsurance.

RECONSTRUCTIVE SURGERY	YOU PAY
(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for Out-of-Pocket Maximum information)	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

SKILLED NURSING FACILITY CARE	YOU PAY
(Applies to Out-of-Pocket Maximum)	$250 per admission Up to 100 days per Accumulation Period

TRANSPLANT SERVICES	YOU PAY
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

VISION SERVICES AND OPTICAL	YOU PAY
Routine eye exam and refraction test when performed by an Optometrist • Members up to the end of the calendar year he/she turns age 19 (Applies to Out-of-Pocket Maximum) • Members age 19 and over (Does not apply to Out-of-Pocket Maximum)	$20 Copayment each visit Not Covered
Routine eye exam and refraction test when performed by an Ophthalmologist • Members up to the end of the calendar year he/she turns age 19 (Applies to Out-of-Pocket Maximum) • Members age 19 and over (Does not apply to Out-of-Pocket Maximum)	$40 Copayment each visit Not Covered
Optical hardware • Members up to the end of the calendar year he/she turns age 19 (Applies to Out-of-Pocket Maximum) • Members age 19 and over (Does not apply to Out-of-Pocket Maximum)	50% Coinsurance Limited to 1 pair of glasses & lenses every 2 years or 2-year supply of contacts Not Covered

X-RAY, LABORATORY AND SPECIAL PROCEDURES	YOU PAY
Diagnostic laboratory Services (Applies to Out-of-Pocket Maximum)	35% Coinsurance
Diagnostic X-ray Services (Applies to Out-of-Pocket Maximum)	35% Coinsurance
Therapeutic X-ray Services (Applies to Out-of-Pocket Maximum)	35% Coinsurance
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine (Applies to Out-of-Pocket Maximum) • Diagnostic procedures include administered drugs. • Therapeutic procedures may incur an additional charge for administered drugs. (See "Office Services" for "Office administered drugs".)	$500 per test Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

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PEDIATRIC DENTAL SERVICES	YOU PAY
Pediatric dental Deductible	$50.00
Diagnostic and Preventive Services (Applies to Out-of-Pocket Maximum) (Limited to Members under the age of 19)	No Charge See limitations listed below
Oral Evaluations - Simple exam - Limited oral exam - Oral exam (under 3 years old) - Complicated exam - Detailed and extensive oral exam	Any combination up to 2 per Accumulation Period
Cleanings - Child prophylaxis (through age 13) - Adult prophylaxis (age 14 up to age 19)	Any combination up to 2 per Accumulation Period
Fluoride - Topical fluoride treatment - Fluoride - varnish	Any combination up to 2 per Accumulation Period
Sealants	Limited to 1 per tooth per Accumulation Period
Bitewing / X-rays - Bitewing – single film - Bitewing – 2 films - Bitewing – 3 films - Bitewing – 4 films - Vertical bitewing – 7 to 8 films	Limited to 1 per Accumulation Period from the following list of bitewing procedures
X-rays - Panoramic film - Full mouth x-rays complete series	Limited to 1 per 60 months
Intraoral / X-rays - Intraoral – first film - Intraoral – additional film	Any combination up to 2 per Accumulation Period
Space Maintainers - Space maintainer – fixed unilateral - Space maintainer – fixed bilateral - Space maintainer – removable unilateral - Space maintainer – removable bilateral - Recementation of space maintainer - Palliative treatment (for pain relief)	Space maintainers limited to 1 per lifetime per primary tooth Limited to 1 per lifetime per tooth Limited to 1 per Accumulation Period

PEDIATRIC DENTAL SERVICES *(continued)*	YOU PAY
Basic Services (Type II) (Applies to Out-of-Pocket Maximum) (Limited to Members under the age of 19) Minor Restorative (fillings) - Amalgam – 1 surface filling (per tooth, per surface) - Amalgam – 2 surface filling (per tooth, per surface) - Amalgam – 3 surface filling (per tooth, per surface) - Amalgam – 4 surface filling (per tooth, per surface) - Resin – 1 surface filling (per tooth, per surface) – front - Resin – 2 surface filling (per tooth, per surface) – front - Resin – 3 surface filling (per tooth, per surface) – front - Resin – 4 surface filling (per tooth, per surface) – front - Resin – 1 surface filling (per tooth, per surface) – back - Resin – 2 surface filling (per tooth, per surface) – back - Resin – 3 surface filling (per tooth, per surface) – back - Resin – 4 surface filling (per tooth, per surface) – back Oral Surgery (Simple Extractions) - Coronal remnants – deciduous tooth - Extraction – erupted tooth - Surgical removal of erupted tooth - Removal of impacted tooth – soft tissue - Removal of impacted tooth – partially bony - Removal of impacted tooth – completely bony Endodontics - Therapeutic pulpotomy – primary tooth - Root canal therapy – anterior - Root canal therapy – bicuspid - Root canal therapy – molar	50% Coinsurance Limited to 2 basic procedures from the following list per Accumulation Period
Major Services (Type III) (Applies to Out-of-Pocket Maximum) (Limited to Members under the age of 19) Crowns - Recement Crown - Crown (steel) - prefab primary tooth - Crown (steel) – prefab permanent tooth - Crown (resin) – anterior tooth - Crown (steel) with resin window – anterior tooth - Sedative filling - Pin retention – per tooth	50% Coinsurance Limited to 1 major procedure from the following list per Accumulation Period
Medically Necessary Orthodontia (Applies to Out-of-Pocket Maximum) (Limited to Members under the age of 19)	50% Coinsurance Limited to medically necessary orthodontia for dental services within the mouth for treatment of a condition related to or resulting from cleft lip and/or cleft palate