(Performance Pipe Hourly Employees)

Dental Plan

CONTENTS

Your Dental Plan Options

Chevron Phillips Chemical Company LP (Chevron Phillips Chemical or the Company) offers eligible employees a choice of dental plans, each administered by Aetna:

- The Preventive Dental Plan (Dental PPO/PDN with PPO II Network), which covers routine preventive care and diagnostic services only, or
- The Comprehensive Dental Plan (Dental PPO/PDN with PPO II Network), which covers a broad range of dental services, including routine and diagnostic services, fillings, dental surgery, major restorations and orthodontia.

For more information on eligibility and enrollment, see pages A-1 – A-7 of the ***How to Participate*** chapter.

Expatriate Employees

Health care benefits are provided to Chevron Phillips Chemical's expatriate employees and their dependents through the Aetna International (AI) program. A separate AI packet will be sent to expatriate employees.

How the Plans Work

PREVENTIVE DENTAL PLAN

The Preventive Dental Plan is designed for employees who expect to have few dental problems. It pays 100% of recognized charges for covered routine preventive and diagnostic care expenses, with no deductible. It does not provide any other benefits. You may use dentists who participate in the Aetna dental network or out-of-network providers. For more information, see ***Recognized Charges*** on page F-3.

When you use an Aetna participating provider, you save money because these participating dentists have agreed to provide their services at discounted rates.

COMPREHENSIVE DENTAL PLAN

The Comprehensive Dental Plan (default coverage if you don't actively enroll upon hire) offers you a choice when you receive dental care. This plan will pay the same level of benefits for care received from any licensed dental provider — regardless of whether they participate in the dental plan provider network.

Because participating dentists have agreed to provide their services at discounted rates, you'll **save** money when you choose to receive care from a participating dentist.

If You Use Non-Participating Dentists

If you use a non-participating dentist, Aetna's payment is based on the fee charged or the recognized charge amount, whichever is less. You're responsible for any costs that exceed the recognized charge. You may also be required to pay a non-participating dentist directly and then submit a claim for reimbursement to Aetna. For more information, see ***Recognized Charges*** on page F-3 and ***How to File a Claim*** on page F-11.

About Participating Providers

The dentists that participate in Aetna's dental network agree to:

- Accept Aetna's negotiated fee — which is usually lower than the fee charged by non-participating dentists — along with your deductible, as payment in full, and
- Handle claim filing for you and receive payment directly from Aetna. You receive an explanation of benefits (EOB) form showing the portion of the charges paid by Aetna and any amount you owe.

Your dentist's office can tell you if he or she participates in the Dental PPO/PDN with PPO II Network. If you have questions about in-network dentists, call Aetna at 1-800-269-5314 or visit the Aetna website at www.aetna.com/docfind/.

Finding Dental Plan Providers

Access the DocFind feature at www.aetna.com/docfind.

Under "Provider Types" — Choose **"Dentists (Primary Care)"** or **"Dental Specialists"**

Under "Plan" — Choose **"Dental PPO/PDN with PPO II"**

Important Features

RECOGNIZED CHARGES

The benefit amount Aetna pays when you see a non-participating dentist is based on the recognized charge. Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it,
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded, or
- The charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished.

In determining the recognized charge for a service or supply that is unusual, or is not often provided in a certain area or is provided by only a small number of providers in the geographic area, Aetna may take into account factors such as:

- The complexity,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and
- The recognized charge in other geographic areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, the recognized charge is the rate established in such agreement.

The benefit paid by the plan after seeing a non-participating dentist (using the recognized charges logic above) may be less than the amount charged by that dentist. If this happens, you are responsible for the difference between the Aetna benefit payment and the dentist's actual charges.

PREDETERMINATION OF BENEFITS

If you are enrolled in the Comprehensive Dental Plan and your dentist recommends treatment for you or a covered dependent (other than routine care) that is expected to cost more than $350, you should ask him or her to request a predetermination of benefits from Aetna. This lets you and the dentist know in advance what services are covered, the dental benefits that will be paid and how much you will have to pay.

To request a predetermination, ask your dentist to complete a claim form describing the planned services and charges and submit the form to Aetna before treatment begins. Both you and your dentist will be notified of the results of the predetermination.

ALTERNATE TREATMENT PROVISION

Sometimes more than one type of dental service can treat the same problem. ***If you are enrolled in the Comprehensive Dental Plan,*** Aetna may decide to authorize coverage only for a less costly service provided that all of the following terms are met:

- The service selected must be deemed to be an appropriate method of treatment by the dental profession,
- The service selected must meet broadly accepted national standards of dental practice, and
- The service selected must customarily be used nationwide for treatment.

You should review the differences in cost of the alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. However, you are responsible for any charges in excess of what the plan will cover.

What the Plans Pay

Although each dental plan pays much or most of covered charges, you share in the cost of covered services through deductibles and applicable co-insurance.

DEDUCTIBLE

The deductible is the amount you pay each plan year for covered dental services before the dental plan begins to pay benefits.

Under the Comprehensive Dental Plan, your deductible is based on the coverage level you elect. There is no deductible under the Preventive Dental Plan.

Your Annual Deductible

	Comprehensive Dental Plan	Preventive Dental Plan
Employee-Only	$ 50	None
Employee + Spouse	$100	None
Employee + Child, one child	$100	None
Employee + Children, two or more children*	$150	None
Employee + Family*	$150	None

** For Employee + Children with two or more children or Employee + Family coverage, the family deductible is met when three or more covered family members' expenses total the $150 family deductible amount.*

CO-INSURANCE

When you incur a covered dental expense, you and the plan share the cost, called co-insurance. After you meet any applicable deductible, the plan pays a percentage of eligible dental charges and you are required to pay the remaining charges. To see how co-insurance is applied to various covered services, see ***Your Dental Plan Options: A Comparison Chart*** on page F-5.

BENEFIT MAXIMUMS

The Comprehensive Dental Plan limits the amount of benefits for covered services paid in any plan year and has a lifetime maximum for orthodontia coverage.

Your Benefit Maximums

	Comprehensive Dental Plan	Preventive Dental Plan
Plan year maximum benefit	$1,750 per person	None
Lifetime maximum orthodontia benefit	$1,750 (adult or child) per person	Not applicable

Your Dental Plan Options: A Comparison Chart

	Comprehensive Dental Plan	Preventive Dental Plan
General Information		
Deductible	$ 50/Employee-Only $100/Employee + Spouse $100/Employee + Child, 1 child $150/Employee + Children, 2+ children $150/Employee + Family	None
Plan year maximum	$1,750/person	None
For the following treatments and services, the dental plan options pay:		
Covered Services		
Diagnostic and preventive care	100%	100%
Basic services*	80%	Not covered
Major services*	50%	Not covered
Orthodontia • Adults • Children • Lifetime maximum	 50% 50% $1,750 per person	 Not covered Not covered Not covered

** Benefits are paid after the deductible is met.*

What's Covered

Dental expenses are divided into four types:

- Type A expenses are for preventive dental services such as oral exams, cleanings and X-rays. To encourage good dental care, Chevron Phillips Chemical's dental benefits cover 100% of diagnostic and preventive services. The deductible does not apply to these services. **The Preventive Dental Plan covers only Type A expenses.**
- Type B expenses are for basic dental services, which include fillings, as well as basic periodontal and some oral surgery services. These expenses are covered under the Comprehensive Dental Plan at 80% after the deductible is met.
- Type C expenses are for major dental services, which include prosthodontics and major surgical and restorative services. These expenses are covered under the Comprehensive Dental Plan at 50% after the deductible is met.
- Orthodontia expenses include those for treatment of dependent children and adults. Benefits for orthodontia expenses are covered under the Comprehensive Dental Plan at 50%, up to the lifetime maximum orthodontia benefit. The deductible does not apply to orthodontia expenses.

BENEFIT SCHEDULE

The following schedule shows what the plan pays for the specific services covered under Chevron Phillips Chemical's dental plans. Claim payments to participating dentists are based on a negotiated schedule of discounted fees. If you use a non-participating dentist, dental benefits are based on recognized charge determinations. For more information, see ***Recognized Charges*** on page F-3.

Covered Service	Plan Benefit	
	Comprehensive Dental Plan	**Preventive Dental Plan**
Type A — Diagnostic & Preventive Care — No Deductible Applies		
Routine oral exams, limited to two per year	100%	100%
X-rays and pathology • Full mouth (including bitewing, if necessary) or panoramic, limited to one set every three years • Bitewing, limited to two sets per year • Periapical X-rays (single films up to 13) • Intra-oral, occlusal view, maxillary or mandibular • Upper or lower jaw, extra-oral	100%	100%
Prophylaxis (cleaning, scaling and polishing), limited to two per year	100%	100%
Fluoride treatments, for children to age 17, limited to two per year	100%	100%
Sealants, for children to age 15, one application every three years; permanent molars only	100%	100%
Space maintainers for children to age 17, unilateral or bilateral, fixed or removable, including adjustments within six months of installation	100%	100%
Type B — Basic Services — Subject to Deductible		
Visits • Professional visit after-hours • Emergency palliative treatment (to temporarily relieve pain)	80%	Not covered
Histopathologic exam of oral tissue	80%	Not covered
Oral surgery • Extractions (uncomplicated; surgical removal of erupted tooth or root tip) • Removal of impacted tooth (soft tissue impaction)	80%	Not covered
Other surgical procedures • Alveoloplasty, per quadrant • Closure of oral fistula • Removal of extostosis • Frenectomy • Transplantation of tooth or tooth bud • Crown exposure to aid eruption	80%	Not covered
Minor restorative services • Amalgam and composite restorations — primary and permanent teeth • Resin restorations • Sedative fillings • Pins, in addition to amalgam, composite or resin restoration • Crowns, when tooth cannot be restored with a filling material – Prefabricated stainless steel – Prefabricated resin • Recementation of inlays, crowns or bridges	80%	Not covered

(continued)

Covered Service	Plan Benefit	
	Comprehensive Dental Plan	Preventive Dental Plan
Type B — Basic Services — Subject to Deductible *(continued)*		
Periodontics • Emergency treatment • Occlusal adjustment, other than with an appliance or by restoration • Subgingival curettage or root planing and scaling, per quadrant, limited to four separate quadrants every two years • Gingivectomy treatment per quadrant, including post-surgical visits, limited to once per quadrant every three years • Gingivectomy treatment per tooth, fewer than three teeth, limited to one per site every three years • Gingival flap procedure per quadrant, including root planing, limited to one per quadrant every three years • Periodontal maintenance procedures, limited to two per year in addition to the two regular cleanings	80%	Not covered
Endodontics • Pulp capping • Apexification/recalcification • Pulpotomy • Apicoectomy • Root canal therapy, anterior or bicuspid teeth, including X-rays	80%	Not covered
Type C — Major Services — Subject to Deductible		
Oral surgery to remove a tooth partially or completely impacted in bone • Typical removal of impacted wisdom teeth	50%	Not covered
Bridge abutments	50%	Not covered
Periodontics • Osseous surgery per quadrant, including post-surgical visits, limited to once per quadrant every three years	50%	Not covered
Endodontics • Root canal therapy, molars, including X-rays	50%	Not covered
Inlays/onlays, resin, metallic or porcelain/ceramic • Inlay, one or more surfaces • Onlay, two or more surfaces	50%	Not covered
Labial veneers • Laminate — chairside • Resin laminate — laboratory • Porcelain laminate — laboratory	50%	Not covered
Crowns • Resin or porcelain with noble or base metal • Full cast, base or noble metal • 3/4 cast, metallic • Post and core • Crown build-ups	50%	Not covered
Pontics: full porcelain, porcelain/resin processed to metal, full cast	50%	Not covered
Removable bridge, unilateral	50%	Not covered

(continued)

Covered Service	Plan Benefit	
	Comprehensive Dental Plan	Preventive Dental Plan
Type C — Major Services — Subject to Deductible *(continued)*		
Dentures and partial dentures, including an interim partial denture, relines, rebase, special tissue conditioning, adjustments and repairs; specialized techniques and characterizations are not eligible; limited to one reline or rebase in any 36 consecutive month period	50%	Not covered
Dental implants	50%	Not covered
Non-surgical Temporomandibular Joint Disorder (TMJ) services	50%	Not covered
Occlusal guard for bruxism, limited to one every three years	50%	Not covered
General anesthesia and intravenous sedation when provided in connection with a covered surgical procedure	50%	Not covered
Orthodontia — No Deductible Applies		
Comprehensive orthodontics of adult or adolescent dentition, including post-treatment stabilization; interceptive and limited orthodontics and orthodontic treatment of transitional dentition (baby teeth)	50%	Not covered
Removable or fixed inhibiting appliance to correct thumbsucking	50%	Not covered

DENTAL/MEDICAL INTEGRATION PROGRAM

The following additional dental expenses will be considered covered expenses for you if you have medical coverage and have at least one of the following conditions:

- Pregnancy,
- Coronary artery disease/cardiovascular disease,
- Cerebrovascular disease, or
- Diabetes.

The additional covered dental expenses include:

- One additional prophylaxis (cleaning) per year,
- Scaling and root planing (four or more teeth), per quadrant,
- Scaling and root planing (limited to 1 – 3 teeth), per quadrant,
- Full mouth debridement,
- Periodontal maintenance (one additional treatment per year), and
- Localized delivery of antimicrobial agents (not covered for pregnancy).

For the additional prophylaxis, the benefit is payable the same as other covered prophylaxis treatments.

For all other covered dental expenses listed above, the plan pays 100% and the additional services will not be subject to any frequency limits (except as listed above) or any plan year maximums.

LIMITATIONS

The replacement of, addition to, or modification of crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services is covered only if one of the following criteria is met:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. Comprehensive Dental Plan coverage must have been in force for the covered person when the extraction took place.
- The existing dentures, crown, bridgework, inlay, onlay or veneer cannot be made serviceable and was installed at least five years before its replacement.
- The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, it cannot be made permanent and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

TOOTH-MISSING-BUT-NOT-REPLACED RULE

Coverage for the first installation of removable dentures, removable bridges and fixed bridgework is subject to the requirements that such dentures, removable bridges and fixed bridgework are:

- Needed to replace one or more natural teeth that were removed while this contract was in force for the covered person, and
- Not abutments to a partial denture, removable bridge or fixed bridge installed during the prior five years.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

What's Not Covered

Chevron Phillips Chemical's dental plans do not cover the following expenses:

- Any services not listed in the ***Benefit Schedule*** on pages F-6 – F-8.
- Basic, Major and Orthodontic services which are not covered under the Preventive Dental Plan.
- Services that are not medically necessary, as determined by Aetna. This applies even if they are prescribed, recommended or approved by your dental provider.
- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.
- Treatment by other than a licensed dentist, except for prophylaxis (cleaning and scaling of teeth) and topical application of fluoride performed by a licensed dental hygienist under the supervision and direction of a dentist.
- Charges submitted for services by an unlicensed provider or a provider not operating within the scope of his/her license.
- Cosmetic surgery, dentistry to correct congenital malformations, plastic surgery, reconstructive surgery, personalization or characterization of dentures or other services or supplies that improve, alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons, except to repair an injury. Surgery must be performed in the calendar year of the accident that caused the injury or in the next calendar year. Facings on molar crowns and pontics will always be considered cosmetic.
- Services or appliances, including crowns, bridges, restoration and root canal therapy, that commenced or were provided before the date the person became covered under the plan or after termination of plan coverage, unless coverage is continued as outlined under ***Benefits for Treatment in Progress After Coverage Terminates*** on page F-12.
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered under the plan.
- Charges for an orthodontic procedure if an active appliance for that procedure was installed before the person was covered under the plan.

- Prescription drugs, laboratory tests and/or exams, pre-medications and relative analgesia (prescription drugs are covered under Chevron Phillips Chemical's prescription drug benefits).
- Hospitalization.
- General anesthesia and/or intravenous sedation except when provided in connection with a covered surgical procedure.
- Charges for completion of claim forms.
- Charges for canceled or missed dental appointments.
- Charges for instructions regarding diet, plaque control and oral hygiene.
- Charges for any dental examinations:
  - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement,
  - Required for securing school admissions or professional or other licenses,
  - Required to travel, attend a school, camp or sporting event or to participate in a sport or other recreational activity, and
  - Any special dental reports not directly related to treatment except when provided as part of a covered service.
- Appliances, surgical procedures or restorations used for the purpose of splinting, to alter vertical dimension, to restore occlusion or to replace tooth structure loss resulting from attrition, abrasion or erosion.
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of damaged appliances due to abuse, misuse or neglect and for an extra set of dentures.
- Services that are experimental or investigational in nature, as determined by Aetna.
- Services and supplies for which the patient is not legally obligated to pay or for which no charge would be made in the absence of dental coverage.
- Services and supplies to diagnose or treat a disease or injury that is an occupational disease or injury related to employment or self-employment including injuries that arise out of (or in the course of) any work for pay or profit.
- Services to treat a dental disease, defect or injury due to an act of war, declared or undeclared.
- Treatment of work-related injuries to sound, natural teeth or services that are covered under workers' compensation or employers' liability laws.
- Certain services related to the treatment of a jaw joint disorder, including but not limited to, Temporomandibular Joint Disorder (TMJ), except as specifically provided.
- Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- A crown, a cast or a processed restoration, unless:
  - It is for the treatment of decay or traumatic injury, and teeth cannot be restored with a filling material, or
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).
- Surgical removal of impacted wisdom teeth only for orthodontic reasons.
- Dental services or supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services.
- Services provided by any government agency, community agency, foundation or similar entity, including programs provided under Title XIX of the Social Security Act or Medicaid.
- Court ordered services, including those required as a condition of parole or release.
- Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.
- Services needed in connection with non-covered services.
- Services that are covered under Chevron Phillips Chemical's medical plan or any other plan provided by Chevron Phillips Chemical. The following services are typically medical in nature and, therefore, are not covered under the dental plan:
  - Biopsy of oral tissue,
  - Incision and drainage of abscess,
  - Removal of cysts or tumors that are dental in origin,
  - Closure of salivary or oral fistula,
  - Sequestrectomy,
  - Suture of soft tissue injury,
  - Removal of salivary calculus,
  - Excision of tissue, and
  - Removal of foreign body from soft tissue.

- The following orthodontic services and supplies:
  - Replacement of broken appliances,
  - Re-treatment of orthodontic cases,
  - Changes in treatment necessitated by an accident,
  - Maxillofacial surgery,
  - Myofunctional surgery,
  - Treatment of micrognathia,
  - Treatment of cleft palate,
  - Treatment of macroglossia,
  - Lingually placed direct bonded appliances and arch wires (i.e., "invisible braces"), and
  - Removable acrylic aligners (i.e., "invisible aligners").

How to File a Claim

IF YOU USE PARTICIPATING DENTISTS

You don't have to file claim-related paperwork. Simply make sure that your dentist knows you are enrolled in an Aetna plan and show your dental ID card. Your dentist's office will verify your eligibility and benefits and handle all claim filing on your behalf.

Aetna reimburses participating dentists directly for covered services. Typically, the dentist's office bills you for your deductible and co-insurance percentage, as well as any non-covered services or supplies.

When your claim is processed, Aetna sends you and your dentist a written explanation of benefits.

IF YOU USE NON-PARTICIPATING DENTISTS

The plan prohibits any assignment of benefit claims or any other types of claims or ERISA rights to a non-participating dentist including, but not limited to, any claims for benefits under the plan, any claim under ERISA or any other applicable law, regardless of the nature of such claims.

Although many dental offices will submit charges to Aetna for reimbursement, you should always check first. If the dentist's office handles claim filing for you, Aetna may pay benefits directly to the dentist. Otherwise, payments will be made directly to you, and you will be responsible for paying the dentist. In the event that Aetna pays the dentist directly, such payment shall in no way be interpreted as a waiver of the plan's prohibition on assignment of benefits.

In some cases, non-participating dentists may ask you to pay up front for dental services and handle claim filing on your own. When this happens, Aetna pays benefits directly to you.

A claim must be submitted to Aetna in writing within 90 days of receiving services. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file it as soon as possible. Unless you are legally incapacitated, late claims for dental benefits will not be covered if they are filed more than two years after the deadline.

Benefits are based on recognized charge determinations. For more information, see ***Recognized Charges*** on page F-3. You are responsible for paying the difference between your dentist's actual charges and the amounts recognized by Aetna, in addition to deductibles and your co-insurance.

When your claim is processed, Aetna sends you and your dentist a written explanation of benefits.

Coordination of Benefits

Many people are covered by more than one dental plan. When this happens, coverage under Chevron Phillips Chemical's dental plan is coordinated with other dental plan coverage you may have. For more information, see ***How Health Care Coordination of Benefits Works*** on page A-20.

Situations That Affect Your Benefits or Coverage

Dental benefits may be affected in the following situations:

- No benefits are payable for treatment you or a dependent receives before coverage under the Chevron Phillips Chemical dental plan becomes effective or after coverage ends, except in the specific situations described here.
- If you decline dental coverage, no benefits are payable.
- If you use a non-participating dentist, you may have to pay the dentist directly for dental services and file a claim for reimbursement.
- If you use a non-participating dentist, you are responsible for paying the difference between what Aetna pays and the dentist's actual charge, in addition to your deductible and/or co-insurance.
- If all or part of your claim is denied, you are entitled to a complete and fair review. For more information on the review process, see the ***Claims*** section beginning on page P-2.
- If a benefit larger than the amount allowed by the plan is paid, the plan has the right to require the return of the overpayment. The plan also has the right to reduce any future benefit payments made to or on behalf of the plan participant by the amount of the overpayment. For more information, see ***Recovery of Excess Payments*** on page P-13.
- As a participant in a Chevron Phillips Chemical benefit plan, you have certain rights under the Employee Retirement Income Security Act of 1974 (ERISA). For information about your rights under ERISA and other important information, see ***Your ERISA Rights*** on page P-14.

Coverage for Dental Work Begun Before You Were Covered by the Plan

Dental services that were provided before you or a covered dependent were covered by the plan are not covered. This means that the following dental services are not covered:

- An appliance, or modification of an appliance, if an impression for it was made before plan coverage began.
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before plan coverage began.
- Root canal therapy, if the pulp chamber for it was opened before plan coverage began.

Benefits for Treatment in Progress After Coverage Terminates

Dental services provided after coverage terminates are not covered. However, when treatment starts while you are covered under the plan, the plan covers "ordered" inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed bridgework and root canals if the item is installed or delivered within 30 days following coverage termination.

For purposes of this continuation coverage, "ordered" means that, prior to the date coverage ends:

- For a denture: impressions for the denture were taken.
- For a root canal: the pulp chamber was opened.
- For any other service listed above: the teeth that are being restored, or that will serve as support or retainers for a bridge or other restoration, were fully prepared to receive the item, and impressions for the item were taken.