

# *City of Austin*



**2020**

## *Employee Dental Assistance Plan Document*

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## ***Helpful Resources***

### **CompuSys/Erisa Group, Inc. (Erisa)**

13706 Research Blvd., Suite 308  
Austin, Texas 78750

Phone number: **512-250-9397**

Toll-free number: 800-933-7472; Relay Texas: 800-735-2989

Office hours: 7:30 a.m. to 5:30 p.m., Monday – Friday

Call for: Dental coverage and claims information

*To check claim status, visit [coadentalplan.com](http://coadentalplan.com)*

### **City of Austin Human Resources Department**

Employee Benefits Division  
505 Barton Springs Road, Suite 600  
Austin, Texas 78704

Phone number: **512-974-3284**

TTY number: 512-974-2445; Relay Texas: 800-735-2989

Fax number: 512-974-3420

Office hours: 7:30 a.m. to 5:00 p.m., Monday – Friday

Call for: Enrollment and adding/dropping dependents

## **2020 Dental Plan Document**

The City of Austin Employee Dental Assistance Plan (the Plan) is an employee benefit provided by the City of Austin (City).

### **Section 1 Plan Provisions**

This document constitutes the entire 2020 Employee Dental Assistance Plan (the Plan) for eligible City employees and their eligible dependents. The Plan does not constitute a contract of employment. Defined terms are capitalized in this document. See Section 10, Dental Plan Documents Definitions.

### **Section 2 Eligibility**

The City will determine eligibility for covered persons enrolled in the Plan. Eligibility guidelines are outlined in the *2020 Employee Benefits Guide*.

If Coverage terminates, benefits will be extended, without premium, only for the following services:

- (A) Dentures, if the final impressions were taken before Coverage ended.
- (B) A crown, bridge, or gold filling, if the tooth was finally prepared and impressions were taken before Coverage ended.
- (C) Root canal work, if the pulp chamber was opened and the canal was explored to the apex before Coverage ended.

These services are covered only if the entire service is completed within 31 days after Coverage has terminated or before the former covered person becomes covered under another dental benefit plan.

### **Section 3 Dental Benefits**

#### **3.1 Maximum Benefits**

The maximum amount of cumulative benefits payable to each covered person, including preventive, basic, major, and Orthodontia Care, is:

- (A) Calendar Year Maximums - \$2,000.
- (B) Orthodontia Lifetime Maximums - \$2,000.  
Orthodontia maximums apply to Calendar Year Maximums.

#### **3.2 Deductible**

Each covered person is required to meet a \$50 Deductible each calendar year before the Plan pays benefits for basic, major, and Orthodontia Care. Except for preventive care, allowable amounts shown on the Table of Allowances in Section 11 are subject to the Deductible.

#### **3.3 Covered Expenses**

The amounts payable under the Plan are listed in the Table of Allowances in this document. Dental services must be performed by or under the supervision of a Dentist and must be essential for the care of the teeth. Dental services must begin while the person is covered under the Plan.

A Covered Expense is considered incurred on the date when:

- (A) The final impression is taken for dentures and partials.
- (B) Fixed bridgework, crowns, inlays, and onlays are prepared to receive the restoration.
- (C) The pulp chamber is opened for root canal therapy.
- (D) Bands and appliances are placed for Orthodontia Care.
- (E) Any other covered service is provided.

##### **3.3.1 Preventive Care**

Covered services include:

- (A) Routine oral examinations, limited to two per Plan Year.
- (B) Intraoral X-rays, limited to one series every five years.
- (C) Bitewing X-rays, limited to two series per Plan Year.
- (D) Prophylaxes (teeth cleanings), limited to two per Plan Year.
- (E) Fluoride Treatment, limited to one per Plan Year. Covered for dependents through age 12 only.
- (F) Sealants. Covered for dependents through age 16 only.
- (G) Emergency treatment for relief of dental pain on a day for which no other benefit, other than X-rays, is payable.

##### **3.3.2 Basic and Major Care**

Except for gold restorations and prosthetics, covered services are limited to:

- (A) Oral Surgery, including extractions, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw.
- (B) Treatment of the gums and supporting structures of the teeth.
- (C) Root canal therapy and other endodontic treatment.

- (D) General anesthetics and their administration.
- (E) Antibiotics and therapeutic injections administered by a Dentist.
- (F) Restorations for teeth broken down by decay or Injury.

### 3.3.3 Limitations

- (A) Services provided must be necessary for:
  - (1) Preventive care.
  - (2) Treatment of dental disease or defect.
  - (3) Treatment of an Injury.
- (B) Covered services for gold restorations and prosthetic services are limited to:
  - (1) Repair and rebasing of existing dentures which have not been replaced by a new denture.
  - (2) Full or partial dentures, fixed bridges, or the addition of teeth to an existing denture.
- (C) Services of a Dental Hygienist are covered only if the Dental Hygienist is working under the supervision of a Dentist.
- (D) Oral exams are Covered Expenses only when service is not duplicated by another procedure performed on the same day.
- (E) Orthodontia Care-eligible expenses are reimbursed at 50% of the allowable charge as work progresses and as the receipts are submitted. Benefits for the initial insertion of appliances will be reimbursed at 50% of allowable charges up to a maximum of \$500, and are included in the calendar year and Orthodontia Lifetime Maximum.
- (F) Replacement of any prosthesis (bridge, denture, crown, or orthodontic appliance) within five years of City coverage after it was first placed is not covered, unless replacement is needed because of initial placement of an opposing full prosthesis or the extraction of teeth; or the prosthesis is a stayplate, or a similar temporary prosthesis, and while in the mouth, has been damaged beyond repair as a result of an Injury occurring while covered. Stolen or lost prostheses are not covered. Temporary or duplicate devices are not covered.

### 3.4 Expenses Not Covered

Covered Expenses do not include, and no payment will be made on the following:

- (A) For Expenses in excess of the amounts listed in the Table of Allowances for the Plan or in excess of the frequency limitations stated in Section 3.3.1 of the Plan.
- (B) Expenses in excess of the Plan calendar year or Orthodontia Lifetime Maximums.

- (C) Services performed for cosmetic reasons, except to correct a congenital anomaly of a Dependent child under 19 years of age.
- (D) Replacement of missing, lost, or stolen appliances.
- (E) Replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability.
- (F) Expenses incurred after termination of coverage except for dental services which were initiated prior to termination, and which were delivered to the covered person within 31 days after the date of termination.
- (G) Dental procedures covered by one of the medical benefit plans sponsored by the City.
- (H) Work-related illness, injury, or complication thereof, arising out of the course of employment.
- (I) Charges which a covered person is not required to pay, including charges for services furnished by any hospital or organization which normally makes no charge if the patient has no hospital, surgical, medical, or dental coverage.
- (J) Appliances or restorations, other than full dentures, whose primary purpose is to alter vertical dimension, stabilize periodontally involved teeth, or restore occlusion.
- (K) Crowns for teeth restorable by other means, or for the purpose of periodontal splinting.
- (L) Drugs or medications other than antibiotic drug injections.
- (M) Bite registration or analysis.
- (N) Instruction, planning, or training services performed for problems associated with diet, oral plaque control, or preventive dental care.
- (O) Precision or semi-precision instruments.
- (P) Implants and related services, except implant supported prosthetics.
- (Q) Transplants.
- (R) Denture duplication.
- (S) Overdentures.
- (T) Charges incurred for missed appointments.
- (U) Night guards.
- (V) Splints.
- (W) Dental services that do not have uniform dental endorsement.

- (X) Placement of bands and regular maintenance of braces, resulting from:
  - (1) Mandibular or maxillofacial surgery to correct growth defects, jaw disproportions, or malocclusion, except for the correction of a congenital anomaly of a Dependent child under 19 years of age.
  - (2) Appliances or restorations used solely to increase vertical dimension, to reconstruct occlusion, or to correct or treat temporomandibular joint (TMJ) dysfunction or TMJ pain syndrome.
- (Y) Temporary restorations.
- (Z) Services for procedures which began prior to the effective date of Coverage under the Plan, including services for Orthodontia Care and prosthetics, if initial treatment or banding began prior to the effective date of Coverage under the Plan.
- (AA) Infection control fees.
- (BB) Charges assessed by the Dentist for the completion of a claim form.
- (CC) Services provided by any government agency, whether Federal, State, County, or City.
- (DD) Non-billed services.

## **Section 4 Predetermination of Benefits**

- (A) Predetermination is a method giving the covered person and the Dentist a better understanding of expenses payable under the Plan before services are provided.  
The Third Party Administrator will use the predetermination to notify the Dentist of the benefits payable for each dental service according to the terms of the Plan.
- (B) Predetermination requires a written report prepared by the attending Dentist as the result of his or her examination of the covered person and providing all of the following:
  - (1) The recommended treatment for the complete correction of any dental disease or injury.
  - (2) The period during which such recommended treatment is to be provided.
  - (3) The estimated cost of the recommended treatment.

Information provided to the Dentist about benefits available will remain in effect for 90 days or until the end of the Plan Year, whichever comes first. The information provided is based on claims history

available when the predetermination is requested. Any actual payment under the Plan is based on claims history available when the Dental Treatment Plan is completed and the actual claim for incurred services is submitted.

- (C) Predetermination of benefits is not required; however, it is recommended so covered persons will know what their expenses will be before dental treatment begins.

If the predetermination of benefits process is not followed, payment will be determined by the Third Party Administrator, taking into account alternate procedures or services, based on acceptable standards of dental practice.

## **Section 5 Submission of Claims**

### **5.1 Claims**

Claims are paid directly to the Employee for covered services, unless benefits are assigned to the provider of service. Notice of claim may be made by submitting a completed and signed claim form together with the original bills for dental expenses incurred from the attending Dentist to the Third Party Administrator. Claim forms are available from the Third Party Administrator or the City.

### **5.2 Limitation of Liability**

Claims for services received more than one year from the date on which services were incurred will not be paid.

### **5.3 Appeals**

The covered person has the right to appeal any benefit determination. To appeal a determination, the covered person must state, in writing, the reason for the appeal and include any additional supporting documentation not already furnished. The appeal should be sent to the Third Party Administrator no later than 30 days after the notice of the claim determination. The Third Party Administrator will review the appeal and make a written determination within 30 days of receipt of the appeal.

Failure to submit a written appeal within the designated time limits will be considered a waiver of the right to appeal.

#### **5.4 Payment of Benefits**

Benefits are payable to the Employee except as provided below in 5.5.

#### **5.5 Incapacity**

If, in the opinion of the Third Party Administrator, a valid release cannot be obtained for payment of any benefit payable under this Plan, the Third Party Administrator may, as its option, make such payment to the individual or individuals who have, in the Third Party Administrator's opinion, assumed the care and principal support of the covered person and are, therefore, equitably entitled thereto. In the event of the death of a covered person prior to such time as all benefit payments due that covered person have been made, the Third Party Administrator may at its sole discretion and option, honor assignments, if any, made prior to the death of the covered person.

#### **5.6 Discharge**

Any payment made by the Plan in accordance with provisions in this Section, will fully discharge the obligations of the Plan to the extent of such payment.

#### **5.7 Claims Recovery**

If, for any reason, the Third Party Administrator makes any payment in excess of the maximum amount necessary to satisfy the intent of the Plan provision, the Third Party Administrator will have the right to recover any excess payments from any other company, organization, or individual to whom, for whom, or with respect to whom, these payments have been made. This includes the right to recover excess payments from the Employee when payment has been made to the Employee.

#### **5.8 Effective Representations**

All statements made by the Plan Administrator or by a covered person will, in the absence of fraud, be considered representations and not warranties, and no statement made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by this document unless contained in a written application for benefits.

#### **5.9 Plan Termination**

The City Manager may terminate the Plan at any time. On termination, the rights of covered persons to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to Employees in writing as soon as administratively feasible.

#### **5.10 Benefits Not Subject to Alienation**

If the Plan Administrator finds that such an attempt has been made with respect to any payment due, or to become due, to any Employee, the Plan Administrator may, in its sole discretion, terminate the interest of such Employee or former Employee in such payment to or for the benefit of such Employee or former Employee, as the Plan Administrator determines, and any such application will be complete discharge of all liability with respect to such benefit payment.

### ***Section 6 Coordination of Benefits***

#### **6.1 Effect of Coverage under Other Plans**

If a covered person is covered under one or more other plans, the benefits payable under this Plan will be reduced by the benefits payable under all other plans so the total payment under this Plan and all other plans does not exceed the Maximum Allowable Charge.

In no event will the payment under this Plan be more than it would have been in the absence of this Coordination of Benefits provision. Benefits payable under all other plans include the benefits that would have been payable had a claim been properly made for them.

#### **6.2 Order of Benefits**

Other plan benefits will be ignored for the purposes of determining the benefits payable by this Plan if the rules set forth in the paragraphs below require this Plan to determine its benefits before such other plans. The services due or the benefits payable under this Plan will be reduced in accordance with the following:

- (A) When the other plan does not have a Coordination of Benefits provision, the other plan is primary.

- (B) When the other plan does have a Coordination of Benefits provision, the following rules govern:
- (1) The plan which covers the covered person as an employee must determine its benefits first.
  - (2) If (B)(1) does not apply, the plan which covers the dependent child of the parent who is born earlier in the year (year of birth is not taken into account) will determine its benefits first, EXCEPT when a claim is made for a dependent child of divorced or separated parents, the following rules will apply:
    - (a) A plan which covers a child as a dependent of a parent who, by court order, must provide health coverage, will determine its benefits first.
    - (b) When there is no court order which requires a parent to provide health coverage to a dependent child, the following rules apply:
      - (i) When a parent who has custody of the child has not remarried, the custodial parent's plan will determine its benefits first.
      - (ii) When a parent who has custody of the child has remarried:
        - A. The custodial parent's plan will determine its benefits first.
        - B. The stepparent's plan will determine its benefits next.
        - C. The plan of the parent without custody will determine its benefits third.
      - (iii) If none of the above rules apply, the plan which has covered the dependent child for a longer period of time will determine its benefits first.
- (C) Where part of the other plan coordinates benefits and a part does not, each part will be treated as a separate plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service provided will be deemed to be both a Covered Service and a benefit paid. The reasonable cash value of any services provided to the covered person by any service organization will be deemed an expense incurred by that covered person, and the liability of the other plan under this agreement will be reduced accordingly.

When the above provisions operate to reduce the total amount of benefits otherwise payable on behalf of a covered person under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision will be reduced

proportionately, and such reduced amount will be charged against any applicable benefit maximum of this Plan.

### **6.3 Right to Receive and Release Information**

For the purpose of determining the applicability of and implementing the terms of Section 6.1, Effect of Coverage under Other Plans, and Section 6.2, Order of Benefits, of this Plan or a similar provision of any other plan, the Third Party Administrator may release to, or obtain from, any other insurance company or other organization or individual, any information concerning any individual, which the Third Party Administrator considers to be necessary for those purposes.

The City and Third Party Administrator will be free from any liability that might arise in relation to such action. Any individual claiming benefits under this Plan will furnish to the Third Party Administrator the information that may be necessary to implement the above provisions.

### **6.4 Payment to Third Party**

Whenever payments which should have been made under this Plan in accordance with Section 6.1, Effect of Coverage under Other Plans, and Section 6.2, Order of Benefits, have been made under any other plan, the Third Party Administrator will have the right to pay to any organizations making these payments any amount it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, the Third Party Administrator and the City will be fully discharged from liability under this Plan.

### **6.5 Subrogation (Third Party Recovery)**

The City will be subrogated to any and all rights of covered persons for recovery against any third party because of a condition, Illness, or Injury caused by such third party or for which such third party may be liable. This right of subrogation is limited to the extent of benefits payable under this Plan for such condition, Illness, or Injury. Upon payment of such benefits:

- (A) Each covered person or his or her legal guardian agrees, as a condition of receiving benefits under the Plan, to reimburse the Plan amounts paid for such claims out of any moneys recovered from any third party as the result of judgment, settlement, or otherwise. In addition, each

covered person agrees to assist the Third Party Administrator in enforcing these rights.

- (B) The Third Party Administrator will be entitled to institute an action in the name of such covered person or to join in an action brought by such covered person against such third party and to participate in any judgment, award, or settlement to the extent of its interest.
- (C) Such covered person will execute such instruments which are necessary for the Plan Administrator to protect its right of subrogation and will refrain from taking any such action which may prejudice the Plan's right of subrogation. Payment by the Plan of any benefits prior to, or without obtaining signed subrogation reimbursement agreement(s), shall not operate as a waiver of this subrogation right. The subrogation reimbursement agreement(s) shall be in a form prescribed by the Plan Administrator.

The covered person agrees, that should the covered person make or file a claim, demand, lawsuit, or reimbursement for the amount of such benefits covered or paid by the Plan the covered person agrees to notify the Third Party Administrator prior to making or filing any such claim, demand, lawsuit or other proceeding. The Third Party Administrator may, at that time or any time, instruct the covered person not to seek, or to discontinue seeking, payment or reimbursement on behalf of the Plan, and the Third Party Administrator may pursue such payment or reimbursement independently in the same or in a separate lawsuit or other proceeding or may abandon such payment or reimbursement altogether, at its sole discretion.

## ***Section 7 Plan Administration Information***

### **7.1 Plan Administrator**

City of Austin  
Human Resources Department  
P.O. Box 1088  
Austin, Texas 78767-1088  
512-974-3284

### **7.2 Third Party Administrator**

CompuSys/Erisa Group, Inc.  
13706 Research Blvd., Suite 308  
Austin, Texas 78750  
512-250-9397 or 800-933-7472

## ***Section 8 Adoption of Plan***

The foregoing provisions are hereby designated as the City of Austin Employee Dental Assistance Plan, and the provisions contained in this Plan are the basis for the

administration of the employee benefit program described in this document.

The Dental Plan Document is effective January 1, 2020.

## ***Section 9 ADA Requirements***

The City and the Third Party Administrator are committed to complying with the Americans with Disabilities Act (ADA). Reasonable accommodation, including equal access to communications, will be provided upon request.

For more information, call the Human Resources Department at 512-974-3400 or 512-974-2445 (TTY line). For any services for which a TTY number is not listed, use the Relay Texas TTY number 800-735-2989 for assistance.

## ***Section 10 Dental Plan Document Definitions***

### **10.1 Course of Treatment**

All treatments performed in the mouth during one or more sessions as the result of the same diagnosis, including any complications arising during such treatment.

### **10.2 Coverage**

Benefits under the Employee Dental Assistance Plan.

### **10.3 Deductible**

The amount of Covered Expenses which the covered person must pay each calendar year before benefits are paid according to the Plan for any Covered Expenses incurred during the calendar year. The Deductible is \$50 per covered person. The Deductible is taken from the allowable amounts shown on the table of allowances. The Deductible does not apply to preventive care.



#### **10.4 Dental Hygienist**

A person who is licensed to practice dental hygiene in the state where the service is performed, working within the scope of that license.

#### **10.5 Dental Treatment Plan**

The attending Dentist's report of recommended treatment that itemizes the necessary procedures and the corresponding charges on a form acceptable to the Third Party Administrator. This report must include supporting pre-operative X-rays and diagnostic materials, as well as the charges for each procedure.

#### **10.6 Dentist**

A person who is licensed to practice dentistry or perform oral surgery in the state where the service is performed, acting within the scope of that license.

#### **10.7 Diagnostic**

The necessary procedures to assist the Dentist in evaluating the covered person's conditions and the dental care required.

#### **10.8 Endodontics**

The necessary procedures for pulpal and root canal surgery.

#### **10.9 Injury**

A bodily injury resulting from a traumatic event or extreme exposure to the elements which requires treatment by a Dentist. To be considered for Coverage under this Plan, such injury must not arise out of the course of any employment or occupation for pay or profit.

#### **10.10 Malocclusion**

A poor relationship between the teeth caused by any of the following:

- (A) Cleft palate.
- (B) Cross bite.
- (C) Congenitally missing permanent teeth.
- (D) Impacted teeth other than third molars.
- (E) Overjet.
- (F) Overbite.
- (G) Crowding.
- (H) Open bite.

#### **10.11 Oral Surgery**

The necessary procedures for extractions and other oral surgery, including pre- and post-operative care.

#### **10.12 Orthodontia Care**

The movement of teeth to correct a Malocclusion pursuant to a Dental Treatment Plan approved by the Third Party Administrator.

#### **10.13 Periodontics**

The necessary procedures for treatment of the tissues supporting the teeth.

#### **10.14 Plan**

The City of Austin Employee Dental Assistance Plan as set forth in this document, and as amended.

#### **10.15 Plan Year**

A period of 12 consecutive months, beginning January 1 and ending December 31.

#### **10.16 Prosthodontics**

The necessary procedures associated with the construction, placement, or repair of fixed bridges, partials, and complete dentures.

#### **10.17 Restorative**

The necessary procedures to restore the teeth with inlays, crowns, and jackets. If a tooth can be restored with amalgam, silicate, or plastic, only payment for these materials will be made toward the cost of any other type of restoration selected by the covered person and the Dentist.

#### **10.18 Third Party Administrator**

The organization responsible for processing payment of dental claims.

### ***Section 11 2020 Table of Allowances***

The Plan will pay up to \$2,000 per covered person per calendar year subject to Plan limitations.

Orthodontia Lifetime Maximum under the Plan is \$2,000 per covered person. All orthodontia benefits paid by the Plan are applied toward the calendar year maximum. After the Deductible is met, benefits are paid at 50% of the maximum allowable amount.

The Table of Allowances for Orthodontia Care lists the type of service and the maximum allowable amount for that service.

Reimbursement for Orthodontia Care is provided only if the member's treatment plan began after he or she became covered under the Plan. Orthodontia Care expenses are paid only as the work progresses and receipts are submitted for reimbursement.

## Preventive Care:

ADA CODE	Preventive Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D0120	Periodic Oral Evaluation	\$63.99
D0140	Limited Oral Evaluation: Problem Focused	\$107.28
D0145	Oral Evaluation for a Patient <3 years of age; counseling with primary caregiver	\$99.76
D0150	Comprehensive Oral Evaluation	\$112.93
D0160	Detailed and Extensive Oral Evaluation: Problem Focused	\$225.86
D0170	Re-valuation: Limited Problem Focused (established patient, not post-operative)	\$75.29
D0171	Re-valuation: Post-Operative Office Visit	\$75.29
D0180	Comprehensive Periodontal Evaluation	\$122.34
D0210	Intraoral: Complete Series of Radiographic Images	\$166.96
D0220	Intraoral: Periapical first Radiographic Image	\$33.39
D0230	Intraoral: Periapical each additional Radiographic Image	\$30.05
D0240	Intraoral: Occlusal Radiographic Image	\$51.76
D0250	Extraoral: 2D Projection Radiographic Image	\$63.45
D0251	Extraoral: Posterior Dental Radiographic Image	\$58.44
D0270	Bitewings: Single Radiographic Image	\$34.15
D0272	Bitewings: 2 Radiographic Images	\$54.64
D0273	Bitewings: 3 Radiographic Images	\$66.60
D0274	Bitewings: 4 Radiographic Images	\$76.84
D0277	Vertical Bitewings: 7 to 8 Radiographic Images	\$116.12
D0310	Sialography	\$476.02
D0330	Panoramic Radiographic Image	\$147.57
D0340	Cephalometric Radiographic Image	\$166.61
D0350	Oral/Facial Images, Obtained Intraorally or Extraorally	\$81.95
D0351	3D Photographic Image	\$79.34
D0415	Collection of Microorganisms for Culture and Sensitivity	\$43.17
D0425	Caries Susceptibility Tests	\$37.22
D0431	Adjunctive Pre-Diagnostic Test that Aids in Detection of Mucosal Abnormalities Including Premalignant and Malignant Lesions, Not to Include Cytology or Biopsy Procedures	\$59.55
D0460	Pulp Vitality Tests	\$60.77
D0486	Accession of Trasepithelial Cytologic Sample, Microscopic Examination and Written Report	\$142.92
D1110	Prophylaxis (teeth cleaning): Adult	\$114.32
D1120	Prophylaxis (teeth cleaning): Through age 12	\$78.90

ADA CODE	Preventive Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D1206	Topical application of fluoride varnish: Through age 12	\$65.27
D1208	Topical application of fluoride: Through age 12	\$43.51
D1351	Sealants per Tooth: Through age 16	\$65.30
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient-Permanent Tooth	\$83.72
D1353	Sealant Repair – per Tooth	\$83.72
D4910	Periodontal Maintenance Procedure (following active therapy)	\$177.75
D9110	Palliative (emergency) Treatment of Dental Pain: Minor	\$149.42
D9310	Consultation (diagnostic service by Dentist other than requesting dentist)	\$209.49
D9430	Office Visit for Observation (regular hours, no other services)	\$66.90
D9910	Application of Desensitizing Medicament	\$80.01
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, per Tooth	\$112.02
D9951	Occlusion Adjustment, Limited	\$194.31
D9952	Occlusion Adjustment, Complete	\$914.41

## Basic Care:

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D2140	Amalgam (silver filling): 1 Surface	\$142.79
D2150	Amalgam (silver filling): 2 Surfaces	\$184.79
D2160	Amalgam (silver filling): 3 Surfaces	\$223.42
D2161	Amalgam (silver filling): 4 or more Surfaces	\$272.14
D2330	Resin: 1 Surface, Anterior	\$147.92
D2331	Resin: 2 Surfaces, Anterior	\$188.78
D2332	Resin: 3 Surfaces, Anterior	\$231.04
D2335	Resin: 4 or more Surfaces, Anterior	\$273.31
D2390	Resin-Based Composite Crown: Anterior	\$302.89
D2391	Resin: 1 Surface, Posterior	\$173.28
D2392	Resin: 2 Surfaces, Posterior	\$226.82
D2393	Resin: 3 Surfaces, Posterior	\$281.76
D2394	Resin: 4 or more Surfaces, Posterior	\$345.16
D3110	Pulp Cap, Direct (excluding final restoration)	\$94.11
D3120	Pulp Cap, Indirect (excluding final restoration)	\$75.29
D3220	Therapeutic Pulpotomy, Remove Pulp and Apply Medications	\$192.92
D3221	Pulpal Debridement: Primary and Permanent Teeth	\$211.74
D3222	Partial Pulpotomy for Apexogenesis Permanent Tooth	\$196.06

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D3230	Pulpal Therapy: Anterior, Primary Tooth (excluding final restoration)	\$179.92
D3240	Pulpal Therapy: Posterior, Primary Tooth (excluding final restoration)	\$221.44
D3310	Endodontic Therapy: Anterior Tooth	\$705.85
D3320	Endodontic Therapy: Premolar Tooth	\$865.01
D3330	Endodontic Therapy: Molar Tooth	\$1,072.61
D3331	Treatment of Root Canal Obstruction; Non-surgical Access	\$276.80
D3332	Incomplete Endodontic Therapy; Inoperative, Unrestorable or Fractured Tooth	\$525.93
D3333	Interior Root Repair of Perforation Defect	\$242.20
D3346	Retreatment of Previous Root Canal Therapy, Anterior	\$941.13
D3347	Retreatment Previous Root Canal Therapy: Premolar	\$1,107.21
D3348	Retreatment of Previous Root Canal Therapy, Molar	\$1,370.18
D3351	Apexification/Recalcification, Initial Visit	\$464.30
D3352	Apexification/Recalcification, Interim Medication Replacement	\$208.14
D3353	Apexification/Recalcification, Final Visit	\$640.42
D3355	Pulpal Regeneration – Initial Visit	\$464.30
D3356	Pulpal Regeneration – Interim Medication Replacement	\$208.14
D3357	Pulpal Regeneration – Completion of Treatment	\$628.09
D3410	Apicoectomy, Anterior	\$920.60
D3421	Apicoectomy, Premolar (First Root)	\$1,024.67
D3425	Apicoectomy, Molar (First Root)	\$1,160.76
D3426	Apicoectomy, each Additional Root	\$392.26
D3427	Periradicular Surgery without Apicoectomy	\$832.54
D3428	Bone Graft in Conjunction with Periradicular Surgery – per Tooth, First Site	\$1,213.59
D3429	Bone Graft in Conjunction with Periradicular Surgery – each Additional Contiguous Tooth in Same Surgical Site	\$1,157.56
D3430	Retrograde Filling, per Root	\$288.19
D3431	Biological Materials to Aid in Soft and Osseous Tissue Regeneration in Conjunction with Periradicular Surgery	\$1,424.93
D3432	Guided Tissue Regeneration, Resorbable Barrier, per Site in Conjunction with Periradicular Surgery	\$1,224.80
D3450	Root Amputation, per Root	\$600.39
D3920	Hemisection (including root removal) without Root Canal Therapy	\$456.30
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	\$208.14
D4210	Gingivectomy/Gingivoplasty, 4 or more Teeth, per Quadrant	\$676.29

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D4211	Gingivectomy/Gingivoplasty, 1 to 3 Teeth, per Quadrant	\$300.57
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth	\$240.46
D4230	Anatomical Crown Exposure, 4 or more Teeth, per Quadrant	\$946.80
D4231	Anatomical Crown Exposure, 1 to 3 Teeth, per Quadrant	\$450.86
D4240	Gingival Flap Procedure including Root Planing, 4 or more Teeth, per Quadrant	\$856.63
D4241	Gingival Flap Procedure including Root Planing, 1 to 3 Teeth, per Quadrant	\$495.95
D4245	Apically Positioned Flap	\$631.20
D4249	Clinical Crown Lengthening, Hard Tissue	\$939.29
D4260	Osseous Surgery (including flap entry and closure), 4 or more Teeth, per Quadrant	\$1,427.72
D4261	Osseous Surgery (including flap entry and closure), 1 to 3 Teeth, per Quadrant	\$766.46
D4263	Bone Replacement Graft – Retained Natural Tooth, First Site in Quadrant	\$510.97
D4264	Bone Replacement Graft – Retained Natural Tooth, each additional site in Quadrant	\$435.83
D4270	Pedicle Soft Tissue Graft Procedure	\$1,014.43
D4273	Autogenous Connective Tissue Graft Procedures (First Tooth)	\$1,239.86
D4275	Non-Autogenous Connective Tissue Graft Procedure (First Tooth)	\$931.78
D4276	Combined Connective Tissue and Double Pedicle Graft, per Tooth	\$1,390.15
D4277	Free Soft Tissue Graft (First Tooth)	\$1,052.00
D4278	Free Soft Tissue Graft, each Additional Tooth	\$345.66
D4283	Autogenous Connective Tissue Graft Procedure, each Additional Tooth	\$1,056.51
D4285	Non-Autogenous Connective Tissue Graft Procedure, each Additional Tooth	\$795.02
D4341	Periodontal Scaling and Root Planing, 4 or more Teeth, per Quadrant	\$230.92
D4342	Periodontal Scaling and Root Planing, 1 to 3 Teeth, per Quadrant	\$133.69
D4346	Scaling, Full Mouth, after Oral Evaluation	\$133.69
D4355	Full Mouth Debridement to Enable Periodontal Evaluation and Diagnosis	\$158.00
D5410	Adjust Complete Denture, Maxillary	\$87.97
D5411	Adjust Complete Denture, Mandibular	\$87.97
D5421	Adjust Partial Denture, Maxillary	\$87.97
D5422	Adjust Partial Denture, Mandibular	\$87.97
D5511	Repair Broken Complete Denture Base, Mandibular	\$175.94
D5512	Repair Broken Complete Denture Base, Maxillary	\$175.94

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D5520	Replace Missing/Broken Teeth, complete Denture Base (each Tooth)	\$146.62
D5611	Repair Resin Partial Denture Base, Mandibular	\$190.60
D5612	Repair Resin Partial Denture Base, Maxillary	\$190.60
D5621	Repair Cast Partial Framework, Mandibular	\$205.26
D5622	Repair Cast Partial Framework, Maxillary	\$205.26
D5630	Repair/Replace Broken Clasp	\$249.25
D5640	Replace Broken Teeth, per Tooth	\$161.28
D5650	Add Tooth to Existing Partial Denture	\$219.92
D5660	Add Clasp to Existing Partial Denture per Tooth	\$263.91
D5710	Rebase Complete Maxillary Denture	\$652.44
D5711	Rebase Complete Mandibular Denture	\$623.12
D5720	Rebase Maxillary Partial Denture	\$615.79
D5721	Rebase Mandibular Partial Denture	\$615.79
D5730	Reline Complete Maxillary Denture (chairside)	\$368.01
D5731	Reline Complete Mandibular Denture (chairside)	\$368.01
D5740	Reline Maxillary Partial Denture (chairside)	\$337.22
D5741	Reline Mandibular Partial Denture (chairside)	\$337.22
D5750	Reline Complete Maxillary Denture (lab)	\$491.16
D5751	Reline Complete Mandibular Denture (lab)	\$491.16
D5760	Reline Maxillary Partial Denture (lab)	\$483.83
D5761	Reline Mandibular Partial Denture (lab)	\$483.83
D5850	Tissue Conditioning, Maxillary	\$153.95
D5851	Tissue Conditioning, Mandibular	\$153.95
D5875	Modification of Removable Prosthesis following Implant Surgery	\$60.00
D5982	Surgical Stent	\$652.44
D6081	Scaling and Debridement in the Presence of Inflammation or Mucositis of a Single Implant, Including Cleaning of the Implant Surface, without Flap Entry and Closure	\$64.51
D6920	Connector Bar	\$258.35
D6930	Recement Fixed Partial Denture	\$150.70
D6940	Stress Breaker	\$341.60
D6950	Precision Attachment	\$660.23
D6980	Fixed Partial Denture, Repair	\$200.00
D7111	Extraction: Coronal Remnants	\$132.88
D7140	Extraction: Erupted Tooth or Exposed Roots	\$176.63
D7210	Surgical Removal: Erupted Tooth	\$254.78
D7220	Removal of Impacted Tooth: Soft Tissue	\$319.46

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D7230	Removal of Impacted Tooth: Partially Bony	\$425.07
D7240	Removal of Impacted Tooth: Completely Bony	\$498.99
D7241	Removal of Impacted Tooth: Completely Bony with Unusual Surgical Complication	\$627.04
D7250	Surgical Removal of Residual Tooth Roots	\$269.30
D7251	Coronectomy – Intentional Partial Tooth Removal	\$528.04
D7260	Oroantral Fistula Closure	\$1,605.67
D7261	Primary Closure of Sinus Perforation	\$669.03
D7270	Tooth Reimplantation and/or Stabilization	\$501.77
D7280	Surgical Access of an Unerupted Tooth	\$468.32
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	\$234.16
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	\$200.71
D7286	Biopsy of Oral Tissue: Soft	\$401.42
D7288	Brush Biopsy: Transepithelial Sample Collection	\$160.57
D7290	Surgical Repositioning of Teeth	\$401.42
D7310	Alveoplasty with Extractions, 4 or more Teeth or Tooth Spaces, per Quadrant	\$309.80
D7311	Alveoplasty in Conjunction with Extractions, 1 to 3 Teeth or Tooth Spaces, per Quadrant	\$271.07
D7320	Alveoplasty without Extractions, 4 or more Teeth or Tooth Spaces, per Quadrant	\$503.42
D7321	Alveoplasty Not in Conjunction w/Extractions, 1 to 3 Teeth or Tooth Spaces, per Quadrant	\$425.97
D7340	Vestibuloplasty, Ridge Extension (secondary epithelization)	\$2,000.00
D7350	Vestibuloplasty, Ridge Extension (with soft tissue graft)	\$2,000.00
D7510	Incision and Drainage of Abscess, Intraoral Soft Tissue	\$333.03
D7511	Incision and Drainage of Abscess, Intraoral Soft Tissue-Complicated (Includes Drainage of Multiple Fascial Spaces)	\$503.42
D7910	Suture Recent Small Wounds, up to 5cm	\$508.07
D7953	Bone Replacement Graft for Ridge Preservation, per Site	\$526.66
D7960	Frenulectomy – (Frenectomy or Frenotomy), separate procedure not incidental to another procedure	\$425.97
D7963	Frenuloplasty	\$697.05
D7970	Excise Hyperplastic Tissue per Arch	\$619.60
D7971	Excise Pericoronal Gingiva	\$232.35
D7972	Surgical Reduction of Fibrous Tuberosity	\$867.44

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D7980	Surgical Sialolithotomy	\$975.86
D9120	Fixed Partial Denture Sectioning	\$135.06
D9210	Local Anesthesia not in Conjunction with Operative or Surgical Procedures	\$50.74
D9211	Regional Block Anesthesia	\$55.99
D9212	Trigeminal Division Block Anesthesia	\$87.49
D9215	Local Anesthesia in Conjunction with Operative or Surgical Procedures	\$42.00
D9219	Evaluation for Deep Sedation or General Anesthesia	\$99.74
D9222	Deep Sedation/General Anesthesia – First 15 Minute Increment	\$297.47
D9223	Deep Sedation/General Anesthesia – each Additional 15 Minute Increment	\$227.48
D9230	Inhalation of Nitrous Oxide/Anxiolysis Analgesia	\$83.99
D9239	IV Conscious Sedation/Analgram – First 15 Minute Increment	\$244.97
D9243	IV Conscious Sedation/Analgram – each Additional 15 Minute Increment	\$192.48
D9248	Non-IV Conscious Sedation	\$122.49
D9995	Teledentistry – Synchronous; Real-Time Encounter	\$292.61
D9996	Teledentistry – Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review	\$219.46

## Major Care:

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D2510	Inlay: Metallic, 1 Surface	\$460.80
D2520	Inlay: Metallic, 2 Surfaces	\$522.76
D2530	Inlay: Metallic, 3 or more Surfaces	\$602.53
D2542	Onlay: Metallic, 2 Surfaces	\$590.91
D2543	Onlay: Metallic, 3 Surfaces	\$618.02
D2544	Onlay: Metallic, 4 or more Surfaces	\$642.80
D2610	Inlay: Porcelain/Ceramic, 1 Surface	\$542.12
D2620	Inlay: Porcelain/Ceramic, 2 Surfaces	\$572.32
D2630	Inlay: Porcelain/Ceramic, 3 or more Surfaces	\$609.50
D2642	Onlay: Porcelain/Ceramic, 2 Surfaces	\$592.46
D2643	Onlay: Porcelain/Ceramic, 3 Surfaces	\$638.93
D2644	Onlay: Porcelain/Ceramic, 4 or more Surfaces	\$677.65
D2650	Inlay: Composite/Resin, 1 Surface	\$356.25
D2651	Inlay: Composite/Resin, 2 Surfaces	\$424.40
D2652	Inlay: Composite/Resin, 3 or more Surfaces	\$446.09
D2662	Onlay: Composite/Resin, 2 Surfaces	\$387.23
D2663	Onlay: Composite/Resin, 3 Surfaces	\$455.38
D2664	Onlay: Composite/Resin, 4 or more Surfaces	\$487.91

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D2710	Crown: Resin-based Composite (indirect)	\$268.79
D2712	Crown: ¾ Resin-based Composite (indirect)	\$268.79
D2720	Crown: Resin with High Noble Metal	\$662.52
D2721	Crown: Resin with Base Metal	\$620.88
D2722	Crown: Resin with Noble Metal	\$634.50
D2740	Crown: Porcelain/Ceramic Substrate	\$679.93
D2750	Crown: Porcelain fused to High Noble Metal	\$670.85
D2751	Crown: Porcelain fused to Base Metal	\$624.66
D2752	Crown: Porcelain fused to Noble Metal	\$639.80
D2753	Crown: Porcelain Fused to Titanium and Titanium Alloys	\$663.70
D2780	Crown: ¾ Cast High Noble Metal	\$643.59
D2781	Crown: ¾ Predominately Base Metal	\$605.73
D2782	Crown: ¾ Noble Metal	\$625.42
D2783	Crown: ¾ Porcelain/Ceramic	\$661.76
D2790	Crown: Full Cast High Noble Metal	\$647.38
D2791	Crown: Full Cast Base Metal	\$613.30
D2792	Crown: Full Cast Noble Metal	\$624.66
D2794	Crown: Titanium and Titanium Alloys	\$662.52
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	\$57.85
D2915	Recement Cast or Prefabricated Post and Core	\$57.85
D2920	Recement Crown	\$58.65
D2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp	\$84.36
D2929	Prefabricated Porcelain/Ceramic Crown – Primary Tooth	\$232.20
D2930	Prefabricated Stainless Steel Crown: Primary Tooth	\$159.89
D2931	Prefabricated Stainless Steel Crown: Permanent Tooth	\$180.78
D2932	Prefabricated Resin Crown	\$192.83
D2933	Prefabricated Stainless Steel Crown with Resin Window	\$220.95
D2934	Prefabricated Esthetic Coated Stainless Steel Crown: Primary Tooth	\$220.95
D2940	Protective Restoration	\$61.06
D2941	Interim Therapeutic Restoration – Primary Dentition	\$61.06
D2949	Restorative Foundation for an Indirect Restoration	\$61.06
D2950	Core Buildup (including any pins when required)	\$152.65
D2951	Pin Retention – per Tooth Addition Restoration	\$34.55
D2952	Post and Core in Addition to Crown, Indirectly Fabricated	\$241.03
D2953	Each Additional Indirectly Fabricated Post, same Tooth	\$120.52
D2954	Prefabricated Post and Core in addition to Crown	\$192.83

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D2955	Post Removal (not in conjunction with endodontic therapy)	\$148.64
D2957	Each additional Prefabricated Post, same Tooth	\$96.41
D2960	Labial Veneer (resin laminate) Chairside	\$466.00
D2961	Labial Veneer (resin laminate) Lab	\$528.67
D2962	Labial Veneer (porcelain laminate) Lab	\$574.46
D2971	Additional Procedures to Construct New Crown Under Existing Partial Denture Framework	\$92.40
D2975	Coping	\$281.21
D2980	Crown Repair Necessitated by Restorative Material Failure	\$112.48
D2981	Inlay Repair Necessitated by Restorative Material Failure	\$112.48
D2982	Onlay Repair Necessitated by Restorative Material Failure	\$112.48
D2983	Veneer Repair Necessitated by Restorative Material Failure	\$112.48
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	\$40.17
D5110	Complete Denture, Maxillary	\$1,004.32
D5120	Complete Denture, Mandibular	\$1,004.32
D5130	Immediate Denture, Maxillary	\$1,095.04
D5140	Immediate Denture, Mandibular	\$1,095.04
D5211	Maxillary Partial Denture, Resin Base	\$847.62
D5212	Mandibular Partial Denture, Resin Base	\$985.08
D5213	Maxillary Partial Denture, Cast Metal Framework with Resin Denture Bases	\$1,109.70
D5214	Mandibular Partial Denture, Cast Metal Framework with Resin Denture Bases	\$1,109.70
D5221	Immediate Maxillary Partial Denture Resin Base	\$924.60
D5222	Immediate Mandibular Partial Denture Resin Base	\$1,073.96
D5223	Immediate Maxillary Partial Denture Cast Metal Framework	\$1,209.58
D5224	Immediate Mandibular Partial Denture Cast Metal Framework	\$1,209.58
D5225	Maxillary Partial Denture: Flexible Base	\$847.62
D5226	Mandibular Partial Denture: Flexible Base	\$985.08
D5282	Removable Unilateral Partial Denture: One Piece Cast Metal, Maxillary	\$646.94
D5283	Removable Unilateral Partial Denture: One Piece Cast Metal, Mandibular	\$646.94
D5284	Removable Unilateral Partial Denture: One Piece Flexible Base, per Quadrant	\$510.15
D5286	Removable Unilateral Partial Denture: One Piece Resin, per Quadrant	\$556.32

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (maxillary)	\$403.19
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (mandibular)	\$403.19
D6058	Abutment Supported Porcelain/Ceramic Crown	\$965.83
D6059	Abutment Supported Porcelain to Metal Crown High Noble Metal	\$953.00
D6060	Abutment Supported Porcelain to Metal Crown Predominantly Base Metal	\$900.77
D6061	Abutment Supported Porcelain to Metal Crown Noble Metal	\$919.10
D6062	Abutment Supported Cast Metal Crown High Noble Metal	\$915.43
D6063	Abutment Supported Cast Metal Crown Predominantly Base Metal	\$797.22
D6064	Abutment Supported Cast Metal Crown Noble Metal	\$833.88
D6065	Implant Supported Porcelain/Ceramic Crown	\$950.25
D6066	Implant Supported Crown Porcelain Fused to High Noble Alloys	\$925.51
D6067	Implant Supported Crown High Noble Alloys	\$898.02
D6068	Abutment Supported Retainer Porcelain/Ceramic FPD	\$957.59
D6069	Abutment Retainer Porcelain to Metal FPD High Noble Metal	\$953.00
D6070	Abutment Retainer Porcelain to Metal FPD Predominantly Base Metal	\$900.77
D6071	Abutment Supported Retainer Porcelain Fused Metal FPD	\$919.10
D6072	Abutment Supported Retainer for Cast Metal FPD	\$930.10
D6073	Abutment Retainer Cast Metal FPD Predominantly Base Metal	\$849.46
D6074	Abutment Retainer Cast Metal FPD Noble Metal	\$902.60
D6075	Implant Supported Retainer for Ceramic FPD	\$950.25
D6076	Implant Supported Retain Porcelain FPD: Porcelain Fused to High Noble Alloys	\$925.51
D6077	Implant Supported Retainer for Cast Metal FPD: High Noble Alloys	\$898.02
D6082	Implant Supported Crown: Porcelain Fused to Predominantly Base Alloys	\$900.77
D6083	Implant Supported Crown: Porcelain Fused to Noble Alloys	\$919.10
D6084	Implant Supported Crown: Porcelain Fused to Titanium and Titanium Alloys	\$925.51
D6085	Implant Supported Crown: Predominantly Base Alloys	\$797.22
D6087	Implant Supported Crown: Noble Alloys	\$833.88

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D6088	Implant Supported Crown: Titanium and Titanium Alloys	\$898.02
D6090	Repair Implant Supported Prosthesis by Report	\$300.00
D6092	Recement Implant/Abutment Supported Crown	\$74.22
D6093	Recement Implant/Abutment Supported Fix Part Denture	\$116.38
D6094	Abutment Supported Crown: Titanium and Titanium Alloys	\$755.99
D6097	Abutment Supported Crown: Porcelain Fused to Titanium and Titanium Alloys	\$953.00
D6098	Implant Supported Retainer: Porcelain Fused to Predominantly Base Alloys	\$900.77
D6099	Implant Supported Retainer for FPD: Porcelain Fused to Titanium and Titanium Alloys	\$953.00
D6120	Implant Supported Retainer: Porcelain Fused to Titanium and Titanium Alloys	\$898.02
D6121	Implant Supported Retainer for Metal FPD: Predominantly Base Alloys	\$797.22
D6122	Implant Supported Retainer for Metal FPD: Noble Alloys	\$833.88
D6123	Implant Supported Retainer for Metal FPD: Titanium and Titanium Alloys	\$930.10
D6110	Implant/Abutment Supported Removable Denture for Edentulous Arch, Maxillary	\$1,252.65
D6111	Implant/Abutment Supported Removable Denture for Edentulous Arch, Mandibular	\$1,252.65
D6112	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch, Maxillary	\$1,252.65
D6113	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch, Mandibular	\$1,252.65
D6194	Abutment Supported Retainer Crown for FPD: Titanium and Titanium Alloys	\$778.90
D6195	Abutment Supported Retainer: Porcelain Fused to Titanium and Titanium Alloys	\$953.00
D6205	Pontic: Indirect Resin – Based Composite	\$439.53
D6210	Pontic: Cast High Noble Metal	\$671.97
D6211	Pontic: Cast Base Metal	\$629.71
D6212	Pontic: Cast Noble Metal	\$655.07
D6240	Pontic: Porcelain fused to High Noble Metal	\$663.52
D6241	Pontic: Porcelain fused to Base Metal	\$612.81
D6242	Pontic: Porcelain fused to Noble Metal	\$646.62
D6243	Pontic: Porcelain Fused to Titanium and Titanium Alloys	\$646.62
D6245	Pontic: Porcelain/Ceramic	\$684.65
D6250	Pontic: Resin with High Noble Metal	\$655.07
D6251	Pontic: Resin with Base Metal	\$604.35

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D6252	Pontic: Resin with Noble Metal	\$623.79
D6545	Retainer: Cast Metal Resin Bonded Fix Prosthesis	\$252.08
D6548	Retainer: Porcelain/Ceramic for Resin Bonded Fixed Prosthesis	\$277.29
D6549	Resin Retainer – for Resin Bonded Fixed Prosthesis	\$181.80
D6600	Retainer Inlay: Porcelain/Ceramic, 2 Surfaces	\$500.34
D6601	Retainer Inlay: Porcelain/Ceramic, 3 or more Surfaces	\$524.78
D6602	Retainer Inlay: Cast High Noble Metal, 2 Surfaces	\$534.71
D6603	Retainer Inlay: Cast High Noble Metal, 3 or more Surfaces	\$588.18
D6604	Retainer Inlay: Cast Predominantly Base Metal, 2 Surfaces	\$524.02
D6605	Retainer Inlay: Cast Predominantly Base Metal, 3 or more Surfaces	\$555.34
D6606	Retainer Inlay: Cast Noble Metal, 2 Surfaces	\$515.62
D6607	Retainer Inlay: Cast Noble Metal, 3 or more Surfaces	\$572.14
D6608	Retainer Onlay: Porcelain/Ceramic, 2 Surfaces	\$543.88
D6609	Retainer Onlay: Porcelain/Ceramic, 3 or more Surfaces	\$567.56
D6610	Retainer Onlay: Cast High Noble Metal, 2 Surfaces	\$576.73
D6611	Retainer Onlay: Cast High Noble Metal, 3 or more Surfaces	\$630.96
D6612	Retainer Onlay: Cast Predominantly Base Metal, 2 Surfaces	\$573.67
D6613	Retainer Onlay: Cast Predominantly Base Metal, 3 or more Surfaces	\$599.64
D6614	Retainer Onlay: Cast Noble Metal, 2 Surfaces	\$561.45
D6615	Retainer Onlay: Cast Noble Metal, 3 or more Surfaces	\$583.60
D6624	Retainer Inlay: Titanium	\$534.71
D6634	Retainer Onlay: Titanium	\$561.45
D6710	Retainer Crown: Indirect Resin – Based Composite	\$572.91
D6720	Retainer Crown: Resin with High Noble Metal	\$668.39
D6721	Retainer Crown: Resin with Predominantly Base Metal Denture	\$634.02
D6722	Retainer Crown: Resin with Noble Metal	\$645.47
D6740	Retainer Crown: Porcelain/Ceramic	\$702.77
D6750	Retainer Crown: Porcelain fused to High Noble Metal Denture	\$684.43
D6751	Retainer Crown: Porcelain fused Predominantly Base Metal	\$638.60
D6752	Retainer Crown: Porcelain fused to Noble Metal	\$653.88

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D6753	Retainer Crown: Porcelain Fused to Titanium and Titanium Alloys	\$653.88
D6780	Retainer Crown: ¾ Cast High Noble Metal	\$645.47
D6781	Retainer Crown: ¾ Cast Predominantly Base Metal	\$645.47
D6782	Retainer Crown: ¾ Cast Noble Metal Denture	\$599.64
D6783	Retainer Crown: ¾ Porcelain/Ceramic Denture	\$664.57
D6784	Retainer Crown: ¾ Titanium and Titanium Alloys	\$645.47
D6790	Retainer Crown: Full Cast High Noble Metal Denture	\$660.75
D6791	Retainer Crown: Full Cast Predominantly Base Metal Denture	\$626.38
D6792	Retainer Crown: Full Cast Noble Metal Denture	\$649.29
D6794	Retainer Crown: Titanium	\$649.29
D6985	Pediatric Partial Denture, Fixed	\$358.82
D9971	Odontoplasty, 1 to 2 Teeth (includes removal of enamel projections)	\$66.29

ADA CODE	Orthodontia Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D8010-D8090	Initial Insertion of Appliances	\$1,000.00
D8210	Removable Appliance Therapy	\$200.00
D8220	Fixed Appliance Therapy	\$200.00
D8660	Pre-Orthodontic Treatment Visit	\$61.84
D8670	Periodic Orthodontic Treatment Visit	\$300.00
D8680	Orthodontic Retention: Removal of Appliance, Placement of Retainer	\$654.40
D8690	Ortho Treatment (alt bill to contract fee)	\$309.21
D8695	Removal of Fixed Orthodontic Appliance for Reasons Other than Completion of Treatment	\$100.00
D8696	Repair of Orthodontic Appliance, Maxillary	\$161.91
D8697	Repair of Orthodontic Appliance, Mandibular	\$161.91
D8889	Ortho Diagnostic Records, Study Model	\$100.00

## Orthodontia Care:

\$2,000 Orthodontia Lifetime Maximum, applied toward Calendar Year Maximum.

ADA CODE	Orthodontia Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
Payable at 50%, after Deductible		
D0470	Diagnostic Casts	\$131.01
D1510	Space Maintainer: Fixed Unilateral, per Quadrant, Excludes a Distal Shoe	\$404.70
D1516	Space Maintainer: Fixed Bilateral, Maxillary	\$566.58
D1517	Space Maintainer: Fixed Bilateral, Mandibular	\$566.58
D1520	Space Maintainer: Removable Unilateral, per Quadrant	\$445.17
D1526	Space Maintainer: Removable Bilateral, Maxillary	\$687.99
D1527	Space Maintainer: Removable Bilateral, Mandibular	\$687.99
D1551	Recement or Re – Bond Bilateral Space Maintainer, Maxillary	\$87.42
D1552	Recement or Re – Bond Bilateral Space Maintainer, Mandibular	\$87.42
D1553	Recement or Re – Bond Unilateral Space Maintainer, per Quadrant	\$87.42
D1556	Removal of Fixed Unilateral Space Maintainer, per Quadrant	\$84.18
D1557	Removal of Fixed Bilateral Space Maintainer, Maxillary	\$84.18
D1558	Removal of Fixed Bilateral Space Maintainer, Mandibular	\$84.18
D1575	Distal Shoe Space Maintainer: Fixed Unilateral, per Quadrant	\$442.90