

City of Austin



2016

Employee Dental Assistance Plan Document

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Helpful Resources

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

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 www.coadentalplan.com

2016 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 2016 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 *2016 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 (cleaning of teeth), 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 that gives 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 that 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 that 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, 2016.

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 2016 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 |
|----------|--|--------------------------|
| 0120 | Periodic Oral Evaluation | 51.10 |
| 0140 | Limited Oral Evaluation: Problem Focused | 85.67 |
| 0145 | Oral Evaluation for a Patient <3 years of age; counseling with primary caregiver | 79.66 |
| 0150 | Comprehensive Oral Evaluation | 90.18 |
| 0160 | Detailed and Extensive Oral Evaluation: Problem Focused | 180.36 |
| 0170 | Re-valuation: Limited Problem Focused (established patient, not post-operative) | 60.12 |
| 0171 | Re-valuation: Post-Operative Office Visit | 66.82 |
| 0180 | Comprehensive Periodontal Evaluation | 97.70 |
| 0210 | Intraoral: Complete Series of radiographic images | 136.94 |
| 0220 | Intraoral: Periapical first radiographic image | 27.39 |
| 0230 | Intraoral: Periapical each additional radiographic image | 24.65 |
| 0240 | Intraoral: Occlusal radiographic image | 42.45 |
| 0250 | Extraoral: First radiographic image | 52.04 |
| 0260 | Extraoral: Each additional radiographic image | 47.93 |
| 0270 | Bitewings: Single radiographic image | 29.10 |
| 0272 | Bitewings: 2 radiographic images | 46.56 |
| 0273 | Bitewings: 3 radiographic images | 56.74 |
| 0274 | Bitewings: 4 radiographic images | 65.47 |
| 0277 | Vertical Bitewings: 7 to 8 radiographic images | 98.94 |

| ADA CODE | Preventive Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|--|--------------------------|
| 0290 | Post-Ant/Lat Skull & Face Bone Survey radiographic image | 143.98 |
| 0310 | Sialography | 359.95 |
| 0330 | Panoramic radiographic image | 111.58 |
| 0340 | Cephalometric radiographic image | 125.98 |
| 0350 | Oral/Facial Images, obtained intraorally or extraorally | 59.99 |
| 0351 | 3D Photographic Image | 68.30 |
| 0415 | Collection of Microorganisms for Culture and Sensitivity | 41.92 |
| 0425 | Caries Susceptibility Tests | 36.14 |
| 0431 | Adjunctive Pre-Diagnostic Test that Aids in Detection of Mucosal Abnormalities | 48.68 |
| 0460 | Pulp Vitality Tests | 57.82 |
| 0486 | Accession of Trasepithelial Cytologic Sample, Microscopic Examination and Written Report | 138.77 |
| 1110 | Prophylaxis (teeth cleaning): Adult | 97.19 |
| 1120 | Prophylaxis (teeth cleaning): Through age 12 | 67.08 |
| 1206 | Topical application of fluoride varnish: Through age 12 | 53.42 |
| 1208 | Topical application of fluoride: Through age 12 | 35.62 |
| 1351 | Sealants per Tooth: Through age 16 | 52.75 |
| 1352 | Preventive Resin Restoration in a Moderate to High Caries Risk Patient-Permanent Tooth | 67.63 |
| 1353 | Sealant Repair – per Tooth | 75.42 |
| 4910 | Periodontal Maintenance Procedure (following active therapy) | 151.15 |
| 9110 | Palliative (emergency) Treatment of Dental Pain: Minor | 122.24 |
| 9310 | Consultation (diagnostic service by dentist other than requesting dentist) | 199.44 |
| 9430 | Office Visit for Observation (regular hours, no other services) | 66.90 |
| 9910 | Application of Desensitizing Medicament | 72.44 |
| 9911 | Application of Desensitizing Resin for Cervical and/or Root Surface, per Tooth | 101.41 |
| 9951 | Occlusion Adjustment, Limited | 175.92 |
| 9952 | Occlusion Adjustment, Complete | 827.86 |

Basic Care:

| ADA CODE | Basic Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|--------------------------------------|--------------------------|
| 2140 | Amalgam (silver filling): 1 Surface | 136.08 |
| 2150 | Amalgam (silver filling): 2 Surfaces | 176.10 |

| ADA CODE | Basic Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|---|--------------------------|
| 2160 | Amalgam (silver filling): 3 Surfaces | 212.92 |
| 2161 | Amalgam (silver filling): 4 or more Surfaces | 259.35 |
| 2330 | Resin: 1 Surface: Anterior | 130.86 |
| 2331 | Resin: 2 Surfaces: Anterior | 167.00 |
| 2332 | Resin: 3 Surfaces: Anterior | 204.39 |
| 2335 | Resin: 4 or More Surfaces: Anterior | 241.78 |
| 2390 | Resin-Based Composite Crown: Anterior | 267.95 |
| 2391 | Resin: 1 Surface: Posterior | 153.29 |
| 2392 | Resin: 2 Surfaces: Posterior | 200.65 |
| 2393 | Resin: 3 Surfaces: Posterior | 249.26 |
| 2394 | Resin: 4 or More Surfaces: Posterior | 305.34 |
| 3110 | Pulp Cap, Direct (excluding final restoration) | 76.65 |
| 3120 | Pulp Cap, Indirect (excluding final restoration) | 61.32 |
| 3220 | Therapeutic Pulpotomy, Remove Pulp and Apply Medications | 157.14 |
| 3221 | Pulpal Debridement: Primary and Permanent Teeth | 172.47 |
| 3222 | Partial Pulpotomy for Apexogenesis Permanent Tooth | 159.69 |
| 3230 | Pulpal Therapy: Anterior, Primary Tooth (excluding final restoration) | 159.34 |
| 3240 | Pulpal Therapy: Posterior, Primary Tooth (excluding final restoration) | 196.11 |
| 3310 | Anterior Root Canal (excluding final restoration) | 625.09 |
| 3320 | Bicuspid Root Canal (excluding final restoration) | 766.05 |
| 3330 | Molar Root Canal (excluding final restoration) | 949.90 |
| 3331 | Treatment of Root Canal Obstruction; Non-surgical Access | 245.13 |
| 3332 | Incomplete Endodontic Therapy; Inoperative, Unrestorable or Fractured Tooth | 465.76 |
| 3333 | Interior Root Repair of Perforation Defect | 214.49 |
| 3346 | Retreatment of previous Root Canal Therapy, Anterior | 833.46 |
| 3347 | Retreatment of previous Root Canal Therapy, Bicuspid | 980.54 |
| 3348 | Retreatment of previous Root Canal Therapy, Molar | 1213.42 |
| 3351 | Apexification/Recalcification, Initial Visit | 452.38 |
| 3352 | Apexification/Recalcification, Interim Medication Replacement | 202.79 |

| ADA CODE | Basic Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|---|--------------------------|
| 3353 | Apexification/Recalcification, Final Visit | 623.97 |
| 3355 | Pulpal Regeneration – Initial Visit | 452.38 |
| 3356 | Pulpal Regeneration – Interim Medication Replacement | 202.79 |
| 3357 | Pulpal Regeneration – Completion of Treatment | 623.97 |
| 3410 | Apicoectomy, Anterior | 896.95 |
| 3421 | Apicoectomy, Bicuspid (First Root) | 998.35 |
| 3425 | Apicoectomy, Molar (First Root) | 1130.94 |
| 3426 | Apicoectomy, (each additional root) | 382.18 |
| 3427 | Periradicular Surgery without Apicoectomy | 811.00 |
| 3428 | Bone Graft in Conjunction with Periradicular Surger-per Tooth, First Site | 1182.19 |
| 3429 | Bone Graft in Conjunction with Periradicular Surger – each Additional Contiguous Tooth in Same Surgical Site | 1127.60 |
| 3430 | Retrograde Filling, per Root | 280.79 |
| 3431 | Biological Materials to Aid in Soft and Osseous Tissue Regeneration in Conjunction with Periradicular Surgery | 1388.06 |
| 3432 | Guided Tissue Regeneration, Resorbable Barrier, per Site in Conjunction with Periradicular Surgery | 1193.11 |
| 3450 | Root Amputation, per Root | 584.97 |
| 3920 | Hemisection (including root removal) without Root Canal Therapy | 444.58 |
| 3950 | Canal Preparation and Fitting of Preformed Dowel or Post | 202.79 |
| 4210 | Gingivectomy/Gingivoplasty, 4 or more Teeth, per Quadrant | 524.04 |
| 4211 | Gingivectomy/Gingivoplasty, 1 to 3 Teeth, per Quadrant | 232.91 |
| 4212 | Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth | 200.77 |
| 4230 | Anatomical Crown Exposure, 4 or more Teeth, per Quadrant | 733.65 |
| 4231 | Anatomical Crown Exposure, 1 to 3 Teeth, per Quadrant | 349.36 |
| 4240 | Gingival Flap Procedure including Root Planing, 4 or more Teeth, per Quadrant | 663.78 |
| 4241 | Gingival Flap Procedure including Root Planing, 1 to 3 Teeth, per Quadrant | 384.29 |
| 4245 | Apically Position Flap | 489.10 |
| 4249 | Clinical Crown Lengthening, Hard Tissue | 727.83 |
| 4260 | Osseous Surgery (including flap entry and closure), 4 or more Teeth, per Quadrant | 1106.30 |

| ADA CODE | Basic Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|--|--------------------------|
| 4261 | Osseous Surgery (including flap entry and closure), 1 to 3 Teeth, per Quadrant | 593.91 |
| 4263 | Bone Replacement Graft, First Site in Quadrant | 395.94 |
| 4264 | Bone Replacement Graft, each additional site in Quadrant | 337.71 |
| 4270 | Pedicle Soft Tissue Graft Procedure | 786.06 |
| 4273 | Subepithelial Connective Tissue Graft Procedures, per Tooth | 960.74 |
| 4275 | Soft Tissue Allograft | 722.01 |
| 4276 | Combined Connective Tissue and Double Pedicle Graft, per Tooth | 1077.19 |
| 4277 | Free Soft Tissue Graft 1 ST Tooth | 878.37 |
| 4278 | Free Soft Tissue Graft, Each Additional Tooth | 288.61 |
| 4341 | Periodontal Scaling and Root Planing, 4 or more Teeth, per Quadrant | 196.36 |
| 4342 | Periodontal Scaling and Root Planing, 1 to 3 Teeth, per Quadrant | 113.68 |
| 4355 | Full Mouth Debridement to Enable Periodontal Evaluation and Diagnosis | 134.35 |
| 5410 | Adjust Complete Denture, Maxillary | 74.43 |
| 5411 | Adjust Complete Denture, Mandibular | 74.43 |
| 5421 | Adjust Partial Denture, Maxillary | 74.43 |
| 5422 | Adjust Partial Denture, Mandibular | 74.43 |
| 5510 | Repair Broken Complete Denture Base | 148.87 |
| 5520 | Replace Missing/Broken Teeth, complete Denture Base (each tooth) | 124.06 |
| 5610 | Repair Resin Denture Base | 161.27 |
| 5620 | Repair Cast Framework | 173.68 |
| 5630 | Repair/Replace Broken Clasp | 210.90 |
| 5640 | Replace Broken Teeth, per Tooth | 136.46 |
| 5650 | Add Tooth to Existing Partial Denture | 186.08 |
| 5660 | Add Clasp to Existing Partial Denture | 223.30 |
| 5710 | Rebase Complete Maxillary Denture | 552.05 |
| 5711 | Rebase Complete Mandibular Denture | 527.24 |
| 5720 | Rebase Maxillary Partial Denture | 521.04 |
| 5721 | Rebase Mandibular Partial Denture | 521.04 |
| 5730 | Reline Complete Maxillary Denture (chairside) | 311.38 |
| 5731 | Reline Complete Mandibular Denture (chairside) | 311.38 |
| 5740 | Reline Maxillary Partial Denture (chairside) | 285.33 |
| 5741 | Reline Mandibular Partial Denture (chairside) | 285.33 |
| 5750 | Reline Complete Maxillary Denture (lab) | 415.59 |
| 5751 | Reline Complete Mandibular Denture (lab) | 415.59 |

| ADA CODE | Basic Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|---|--------------------------|
| 5760 | Reline Maxillary Partial Denture (lab) | 409.38 |
| 5761 | Reline Mandibular Partial Denture (lab) | 409.38 |
| 5850 | Tissue Conditioning, Maxillary | 130.26 |
| 5851 | Tissue Conditioning, Mandibular | 130.26 |
| 5875 | Modification of Removable Prosthesis following Implant Surgery | 60.00 |
| 5982 | Surgical Stent | 552.05 |
| 6920 | Connector Bar | 219.87 |
| 6930 | Recement Fixed Partial Denture | 128.26 |
| 6940 | Stress Breaker | 290.71 |
| 6950 | Precision Attachment | 561.88 |
| 6980 | Fixed Partial Denture, Repair | 200.00 |
| 7111 | Extraction: Coronal Remnants | 112.15 |
| 7140 | Extraction: Erupted Tooth or Exposed Roots | 149.08 |
| 7210 | Surgical Removal: Erupted Tooth | 228.86 |
| 7220 | Removal of Impacted Tooth: Soft Tissue | 286.96 |
| 7230 | Removal of Impacted Tooth: Partially Bony | 381.83 |
| 7240 | Removal of Impacted Tooth – Completely Bony | 480.90 |
| 7241 | Removal of Impacted Tooth: Completely Bony with Unusual Surgical Complication | 563.25 |
| 7250 | Surgical Removal of Residual Tooth Roots | 241.90 |
| 7251 | Coronectomy – Intentional Partial Tooth Removal | 474.32 |
| 7260 | Oroantral Fistula Closure | 1407.08 |
| 7261 | Primary Closure of Sinus Perforation | 586.28 |
| 7270 | Tooth Reimplantation and/or Stabilization | 439.71 |
| 7280 | Surgical Access of an Unerupted Tooth | 410.40 |
| 7282 | Mobilization of Erupted or Malpositioned Tooth to Aid Eruption | 205.20 |
| 7283 | Placement of Device to Facilitate Eruption of Impacted Tooth | 175.89 |
| 7286 | Biopsy of Oral Tissue: Soft | 351.77 |
| 7288 | Brush Biopsy: Transepithelial Sample Collection | 140.71 |
| 7290 | Surgical Repositioning of Teeth | 351.77 |
| 7310 | Alveoloplasty with Extractions, 4 or more Teeth or Tooth Spaces, per Quadrant | 331.82 |
| 7311 | Alveoloplasty in Conjunction with Extractions, 1 to 3 Teeth or Tooth Spaces, per Quadrant | 290.34 |
| 7320 | Alveoloplasty without Extractions, 4 or more Teeth or Tooth Spaces, per Quadrant | 539.20 |

| ADA CODE | Basic Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|---|--------------------------------|
| 7321 | Alveoloplasty Not in Conjunction w/Extractions, 1 to 3 Teeth or Tooth Spaces, per Quadrant | 456.25 |
| 7340 | Vestibuloplasty, Ridge Extension (secondary epithelization) | 1800.00 |
| 7350 | Vestibuloplasty, Ridge Extension (with soft tissue graft) | 1800.00 |
| 7510 | Incision and Drainage of Abscess, Intraoral Soft Tissue | 356.70 |
| 7511 | Incision & Drainage of Abscess, Intraoral Soft Tissue-Complicated (including drainage of multiple fascial spaces) | 539.20 |
| 7910 | Suture Recent Small Wounds, up to 5cm | 544.18 |
| 7953 | Bone Replacement Graft for Ridge Preservation, Per Site | 282.04 |
| 7960 | Frenulectomy – (Frenectomy or Frenotomy), separate procedure not incidental to another procedure | 456.25 |
| 7963 | Frenuloplasty | 746.59 |
| 7970 | Excise Hyperplastic Tissue per Arch | 663.63 |
| 7971 | Excise Pericoronal Gingiva | 248.86 |
| 7972 | Surgical Reduction of Fibrous Tuberosity | 929.08 |
| 7980 | Sialolithotomy | 1045.22 |
| 9120 | Fixed Partial Denture Sectioning | 110.50 |
| 9210 | Local Anesthesia not in Conjunction with Operative or Surgical Procedures | 39.44 |
| 9211 | Regional Block Anesthesia | 43.52 |
| 9212 | Trigeminal Division Block Anesthesia | 67.99 |
| 9215 | Local Anesthesia in Conjunction with Operative or Surgical Procedures | 32.64 |
| 9220 | General Anesthesia, First 30 minutes | 394.36 |
| 9221 | General Anesthesia, Each add'l 15 minutes | 176.78 |
| 9230 | Inhalation of Nitrous Oxide/Anxiolysis Analgesia | 65.27 |
| 9241 | Intravenous Sedation/Analgesia: First 30 minutes | 305.97 |
| 9242 | Intravenous Sedation/Analgesia: Each additional 15 minutes | 149.58 |
| 9248 | Non-IV Conscious Sedation | 95.19 |

Major Care:

| ADA CODE | Major Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|-------------------------------------|--------------------------------|
| 2510 | Inlay: Metallic, 1 Surface | 432.63 |
| 2520 | Inlay: Metallic, 2 Surfaces | 490.80 |
| 2530 | Inlay: Metallic, 3 or more Surfaces | 565.70 |
| 2542 | Onlay: Metallic, 2 Surfaces | 554.79 |
| 2543 | Onlay: Metallic, 3 Surfaces | 580.24 |

| ADA CODE | Major Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|--|--------------------------------|
| 2544 | Onlay: Metallic, 4 or more Surfaces | 603.51 |
| 2610 | Inlay: Porcelain/Ceramic: 1 Surface | 508.98 |
| 2620 | Inlay: Porcelain/Ceramic: 2 Surfaces | 537.34 |
| 2630 | Inlay: Porcelain/Ceramic: 3 or more Surfaces | 572.24 |
| 2642 | Onlay: Porcelain/Ceramic: 2 Surfaces | 556.24 |
| 2643 | Onlay: Porcelain/Ceramic: 3 Surfaces | 599.87 |
| 2644 | Onlay: Porcelain/Ceramic: 4 or more Surfaces | 636.23 |
| 2650 | Inlay: Composite/Resin: 1 Surface | 334.47 |
| 2651 | Inlay: Composite/Resin: 2 Surfaces | 398.46 |
| 2652 | Inlay: Composite/Resin: 3 or more Surfaces | 418.82 |
| 2662 | Onlay: Composite/Resin: 2 Surfaces | 363.56 |
| 2663 | Onlay: Composite/Resin: 3 Surfaces | 427.54 |
| 2664 | Onlay: Composite/Resin: 4 or more Surfaces | 458.08 |
| 2710 | Crown: Resin-based Composite (indirect) | 242.97 |
| 2712 | Crown: ¾ Resin-based Composite (indirect) | 242.97 |
| 2720 | Crown: Resin with High Noble Metal | 598.87 |
| 2721 | Crown: Resin with Base Metal | 561.22 |
| 2722 | Crown: Resin with Noble Metal | 573.54 |
| 2740 | Crown: Porcelain/Ceramic Substrate | 614.61 |
| 2750 | Crown: Porcelain fused to High Noble Metal | 606.40 |
| 2751 | Crown: Porcelain fused to Base Metal | 564.65 |
| 2752 | Crown: Porcelain fused to Noble Metal | 578.33 |
| 2780 | Crown: ¾ Cast High Noble Metal | 581.76 |
| 2781 | Crown: ¾ Predominately Base Metal | 547.54 |
| 2782 | Crown: ¾ Noble Metal | 565.33 |
| 2783 | Crown: ¾ Porcelain/Ceramic | 598.18 |
| 2790 | Crown: Full Cast High Noble Metal | 585.18 |
| 2791 | Crown: Full Cast Base Metal | 554.38 |
| 2792 | Crown: Full Cast Noble Metal | 564.65 |
| 2794 | Crown: Titanium | 598.87 |
| 2910 | Recement Inlay, Onlay or Partial Coverage Restoration | 52.02 |
| 2915 | Recement Cast or Prefabricated Post and Core | 52.02 |
| 2920 | Recement Crown | 52.74 |
| 2921 | Reattachment of Tooth Fragment, Incisal Edge or Cusp | 81.24 |
| 2929 | Prefabricated Porcelain/Ceramic Crown-Primary Tooth | 212.45 |
| 2930 | Stainless Steel Crown: Primary Tooth | 143.78 |
| 2931 | Stainless Steel Crown: Permanent Tooth | 162.56 |
| 2932 | Prefabricated Resin Crown | 173.40 |
| 2933 | Prefabricated Stainless Steel Crown with Resin Window | 198.69 |
| 2934 | Prefabricated Esthetic Coated Stainless Steel Crown: Primary Tooth | 198.69 |

| ADA CODE | Major Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|---|--------------------------|
| 2940 | Protective Restoration | 54.91 |
| 2941 | Interim Therapeutic Restoration-Primary Dentition | 58.80 |
| 2949 | Restorative Foundation for an Indirect Restoration | 58.80 |
| 2950 | Core Buildup (including any pins when required) | 137.27 |
| 2951 | Pin Retention - per Tooth Addition Restoration | 31.07 |
| 2952 | Post and Core in addition to Crown, Indirectly Fabricated | 216.75 |
| 2953 | Each additional Indirectly Fabricated Post, same Tooth | 108.37 |
| 2954 | Prefabricated Post and Core in addition to Crown | 173.40 |
| 2955 | Post Removal (not in conjunction with endodontic therapy) | 133.66 |
| 2957 | Each additional Prefabricated Post, same Tooth | 86.70 |
| 2960 | Labial Veneer (resin laminate) Chairside | 419.05 |
| 2961 | Labial Veneer (resin laminate) Lab | 475.40 |
| 2962 | Labial Veneer (porcelain laminate) Lab | 516.58 |
| 2971 | Additional Procedures to Construct New Crown Under Existing Partial Denture Framework | 83.09 |
| 2975 | Coping | 252.87 |
| 2980 | Crown Repair | 106.00 |
| 5110 | Complete Denture, Maxillary | 849.78 |
| 5120 | Complete Denture, Mandibular | 849.78 |
| 5130 | Immediate Denture, Maxillary | 926.54 |
| 5140 | Immediate Denture, Mandibular | 926.54 |
| 5211 | Maxillary Partial Denture, Resin Base | 717.20 |
| 5212 | Mandibular Partial Denture, Resin Base | 833.50 |
| 5213 | Maxillary Partial Denture, Cast Metal Framework with Resin Denture Bases | 938.95 |
| 5214 | Mandibular Partial Denture, Cast Metal Framework with Resin Denture Bases | 938.95 |
| 5225 | Maxillary Partial Denture: Flexible Base (including any clasps rests and teeth) | 717.20 |
| 5226 | Mandibular Partial Denture: Flexible Base (including any clasps rests and teeth) | 833.50 |
| 5281 | Removable Unilateral Partial Denture, One Piece Cast Metal | 547.40 |
| 5670 | Replace All Teeth and Acrylic on Cast Metal Framework (maxillary) | 341.15 |
| 5671 | Replace All Teeth and Acrylic on Cast Metal Framework (mandibular) | 341.15 |
| 6058 | Abutment Supported Porcelain/Ceramic Crown | 817.22 |
| 6059 | Abutment Supp Porcelain to Metal Crown High Noble Metal | 806.36 |
| 6060 | Abutment Supp Porcelain to Metal Crown Predom Base Metal | 762.17 |
| 6061 | Abutment Supp Porcelain to Metal Crown Noble Metal | 777.68 |

| ADA CODE | Major Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|---|--------------------------|
| 6062 | Abutment Supp Cast Metal Crown High Noble Metal | 774.57 |
| 6063 | Abutment Supp Cast Metal Crown Predom Base Metal | 674.55 |
| 6064 | Abutment Supp Cast Metal Crown Noble Metal | 705.57 |
| 6065 | Implant Supported Porcelain/Ceramic Crown | 804.04 |
| 6066 | Implant Supported Porcelain Fused to Metal Crown | 783.10 |
| 6067 | Implant Supported Metal Crown | 759.84 |
| 6068 | Abutment Supported Retainer Porcelain/Ceramic FPD | 810.24 |
| 6069 | Abutment Retainer Porcelain to Metal FPD High Noble Metal | 806.36 |
| 6070 | Abutment Retainer Porcelain to Metal FPD Predom Base Metal | 762.17 |
| 6071 | Abutment Supported Retainer Porcelain Fused Metal FPD | 777.68 |
| 6072 | Abutment Supported Retainer for Cast Metal FPD | 786.98 |
| 6073 | Abutment Retainer Cast Metal FPD Predom Base Metal | 718.75 |
| 6074 | Abutment Retainer Cast Metal FPD Noble Metal | 763.72 |
| 6075 | Implant Supported Retainer for Ceramic FPD | 804.04 |
| 6076 | Implant Supported Retain Porcelain Fused Metal FPD | 783.10 |
| 6077 | Implant Supported Retainer for Cast Metal FPD | 759.84 |
| 6090 | Repr Implant Supp Prosth by Report | 300.00 |
| 6092 | Recement Implant/Abut Supported Crown | 62.80 |
| 6093 | Recement Implant/Abutment Supported Fix Part Denture | 98.47 |
| 6094 | Abutment Supported Crown-Titanium | 639.66 |
| 6110 | Implant/Abutment Supported Removable Denture for Edentulous Arch-Maxillary | 1130.81 |
| 6111 | Implant/Abutment Supported Removable Denture for Edentulous Arch-Mandibular | 1130.81 |
| 6112 | Implant/Abutment Supported Removable Denture for Partially Edentulous Arch-Maxillary | 1130.81 |
| 6113 | Implant/Abutment Supported Removable Denture for Partially Edentulous Arch-Mandibular | 1130.81 |
| 6194 | Abutment Supported Retainer Crown for FPD – Titanium | 659.05 |
| 6205 | Pontic: Indirect Resin-Based Composite | 381.85 |
| 6210 | Pontic: Cast High Noble Metal | 583.80 |
| 6211 | Pontic: Cast Base Metal | 547.08 |
| 6212 | Pontic: Cast Noble Metal | 569.11 |
| 6214 | Pontic: Titanium | 587.47 |

| ADA CODE | Major Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|---|--------------------------|
| 6240 | Pontic: Porcelain fused to High Noble Metal | 576.45 |
| 6241 | Pontic: Porcelain fused to Base Metal | 532.39 |
| 6242 | Pontic: Porcelain fused to Noble Metal | 561.77 |
| 6245 | Pontic: Porcelain/Ceramic | 594.81 |
| 6250 | Pontic: Resin with High Noble Metal | 569.11 |
| 6251 | Pontic: Resin with Base Metal | 525.05 |
| 6252 | Pontic: Resin with Noble Metal | 541.94 |
| 6545 | Retainer: Cast Metal Resin Bonded Fixed Prosthesis | 225.75 |
| 6548 | Retainer: Porcelain/Ceramic for Resin Bonded Fixed Prosthesis | 248.32 |
| 6549 | Resin Retainer – for Resin Bonded Fixed Prosthesis | 171.42 |
| 6600 | Inlay: Porcelain/Ceramic, 2 Surfaces | 448.08 |
| 6601 | Inlay: Porcelain/Ceramic, 3 or More Surfaces | 469.97 |
| 6602 | Inlay: Cast High Noble Metal, 2 Surfaces | 478.86 |
| 6603 | Inlay: Cast High Noble Metal, 3 or More Surfaces | 526.75 |
| 6604 | Inlay: Cast Base Metal, 2 Surfaces | 469.28 |
| 6605 | Inlay: Cast Base Metal, 3 or More Surfaces | 497.33 |
| 6606 | Inlay: Cast Noble Metal, 2 Surfaces | 461.76 |
| 6607 | Inlay: Cast Noble Metal, 3 or More Surfaces | 512.38 |
| 6608 | Onlay: Porcelain/Ceramic, 2 Surfaces | 487.07 |
| 6609 | Onlay: Porcelain/Ceramic, 3 or More Surfaces | 508.28 |
| 6610 | Onlay: Cast High Noble Metal, 2 Surfaces | 516.48 |
| 6611 | Onlay: Cast High Noble Metal, 3 or More Surfaces | 565.05 |
| 6612 | Onlay: Cast Base Metal, 2 Surfaces | 513.75 |
| 6613 | Onlay: Cast Base Metal, 3 or More Surfaces | 537.01 |
| 6614 | Onlay: Cast Noble Metal, 2 Surfaces | 502.80 |
| 6615 | Onlay: Cast Noble Metal, 3 or More Surfaces | 522.64 |
| 6624 | Inlay: Titanium | 478.86 |
| 6634 | Onlay: Titanium | 502.80 |
| 6710 | Crown: Indirect Resin-Based Composite | 513.06 |
| 6720 | Crown: Resin with High Noble Metal | 598.57 |
| 6721 | Crown: Resin with Base Metal | 567.79 |
| 6722 | Crown: Resin with Noble Metal | 578.05 |
| 6740 | Crown: Porcelain/Ceramic | 629.36 |
| 6750 | Crown: Porcelain fused to High Noble Metal | 612.94 |
| 6751 | Crown: Porcelain fused to Base Metal | 571.90 |
| 6752 | Crown: Porcelain fused to Noble Metal | 585.58 |
| 6780 | Crown: ¾ Cast Base Metal | 578.05 |
| 6781 | Crown: ¾ Cast Predominantly Base Metal | 578.05 |
| 6782 | Crown: ¾ Noble Metal | 537.01 |
| 6783 | Crown: ¾ Porcelain/Ceramic | 595.15 |

| ADA CODE | Major Care TYPE OF SERVICE | MAXIMUM ALLOWABLE AMOUNT |
|----------|---|--------------------------|
| 6790 | Crown: Full Cast High Noble Metal | 591.73 |
| 6791 | Crown: Full Cast Base Metal | 560.95 |
| 6792 | Crown: Full Cast Noble Metal | 581.47 |
| 6794 | Crown: Titanium | 581.47 |
| 6985 | Pediatric Partial Denture, Fixed | 305.37 |
| 9971 | Odontoplasty, 1 to 2 Teeth (includes removal of enamel projections) | 60.02 |

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 | | |
| 0470 | Diagnostic Casts | 127.21 |
| 1510 | Space Maintainer: Fixed Unilateral | 361.00 |
| 1515 | Space Maintainer: Fixed Bilateral | 505.40 |
| 1520 | Space Maintainer: Removable Unilateral | 397.10 |
| 1525 | Space Maintainer: Removable Bilateral | 613.70 |
| 1550 | Recementation Space Maintainer | 77.98 |
| 1555 | Removal of Fixed Space Maintainer | 75.09 |
| 8000 – 8090 | Initial Insertion of Appliances | 1000.00 |
| 8210 | Removable Appliance Therapy | 200.00 |
| 8220 | Fixed Appliance Therapy | 200.00 |
| 8660 | Pre-Orthodontic Treatment Visit | 61.84 |
| 8670 | Periodic Orthodontic Treatment Visit | 300.00 |
| 8680 | Orthodontic Retention: Removal of Appliance, Placement of Retainer | 654.40 |
| 8690 | Ortho Treat (alt bill to contract fee) | 309.21 |
| 8691 | Repair Orthodontic Appliance | 161.91 |
| 8889 | Ortho Diagnostic Records, Study Model | 100.00 |