Administered by:

BlueCross BlueShield of Texas

Your Health Care Benefits Program

Dental Benefits

Current Dental Terminology© American Dental Association

City of Austin

BlueCare Dental PPO

Account #246681

Group #300189 Retirees

January 1, 2022

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Helpful Resources

Blue Cross and Blue Shield of Texas (BCBSTX)
Claims Administrator
Phone number: **888-907-7880**
Office hours: 8:00 a.m. to 6:00 p.m., Monday – Friday

Call for: Dental coverage and claims information

Website: www.bcbstx.com/coa *2*4 hours a day, 7 days a week

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: 8:00 a.m. to 5:00 p.m., Monday – Friday

Call for: Enrollment and adding/dropping dependents

Section 1 Plan Provisions

This document constitutes the entire 2022 BlueCare Dental PPO (the Plan) for eligible City retirees and their eligible dependents. The Plan does not constitute a contract of employment. Defined terms are capitalized in this document. See DEFINITIONS section of this Benefit Booklet.

Section 2 Eligibility

The City will determine eligibility for covered persons enrolled in the Plan. Eligibility guidelines are outlined in the *2022 Retiree Benefits Guide*.

If Coverage terminates, benefits will be extended, without premium, for 31 days after Coverage has terminated or coverage goes into effect for another dental plan, for the following services:

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

Section 3 How the Plan Works

BlueCare Dental PPO

In-Network Coverage – Your out-of-pocket will be less when choosing an In-Network Provider. In-Network Providers have signed an agreement with BCBSTX to accept the Allowable Amount as payment in full. Such Participating Providers have agreed to not bill you for Covered Service amounts over the Allowable Amount. Therefore, you will be responsible only for the $50 Calendar Year deductible, if it has not already been met.

Out-of-Network Coverage – Your out-of-pocket will be greater when choosing an Out-of-Network Provider. Out-of-Network Providers have not signed an agreement with BCBSTX to accept the Allowable Amount as payment in full. Therefore, you are responsible for the amount billed over the Table of Allowance and the $50 Calendar Year deductible, if it has not already been met.

Allowable Amount

The Allowable Amount is the maximum amount of benefits BCBSTX will pay for Eligible Dental Expenses you incur under the Plan

Review the definition of Allowable Amount in the DEFINITIONS section of this Benefit Booklet to understand the guidelines used by BCBSTX.

Course of Treatment

In cases where there is more than one professionally acceptable covered procedure or Course of Treatment, benefits will be covered for the least costly procedure or Course of Treatment, as determined by the Plan. If the Participant requests or accepts a more costly service, the person is responsible for expenses that exceed the amount covered for the least costly service.

<table>
<tr><td colspan="2">Each time you need dental care, you can choose:</td></tr>
<tr><td>An In-Network Provider</td><td>An Out-of-Network Provider</td></tr>
<tr><td>Less out-of-pocket maximums. Providers have contracted toaccept a lower Allowable Amount as payment in full for Eligible Dental Expenses.
You are not required to file a claim.
You are not balanced billed for costs exceeding BCBSTX’s Allowable Amount for In-Network Provider.</td><td>Reimbursement based on the Table of Allowance.
You or the Out-of-Network Provider are required to file a claim form(s).
You may be balanced billed for costs exceeding the Table of Allowance.</td></tr>
<tr><td colspan="2">In each event as described above you will be responsible for the following:
Any applicable Deductibles;
Services that are limited or not covered under the Plan.
If your Provider is not an In-Network Provider, you may be responsible for payment in full at the time services are rendered.
To find an In-Network Provider, log on to the BCBSTX website at www.bcbstx.com/coa and search for a Provider using ProviderFinder, or call the Dental Customer Service 888-907-7880.</td></tr>
</table>

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's dental care Plan with BCBSTX. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- Your Subscriber identification number.
- Your group number. This is the number assigned to identify your Employer's dental care Plan.

Remember to carry your Identification Card and present it to your Provider when receiving dental care services orsupplies.

Please remember that any time a change in your family occurs, it may be necessary for a new Identification Card to be issued to you (refer to the **DENTAL BENEFITS** section for instructions). Upon receipt of the change in information, BCBSTX will provide a new Identification Card.

Predetermination of Benefits

If a Course of Treatment for non-emergency services can reasonably be expected to involve Eligible Dental Expenses in excess of $300, a description of the procedures to be performed and an estimate of the Provider's chargeshould be filed with and predetermined by BCBSTX prior to the commencement of treatment.

BCBSTX may request copies of existing radiographic images, photographs, models, and any other records used by the Provider in developing the Course of Treatment. BCBSTX will review the reports and materials, taking into consideration alternative Courses of Treatment. BCBSTX will notify you and the Provider of the benefits to be provided under the Plan. Predetermination gives you and your Provider the opportunity to know the extent of the benefits available. Benefit payments may be reduced based on any claims paid after a predetermination estimate is provided.

Section 4 Dental Benefits

Maximum Benefits

The maximum amount of cumulative benefits payable to each covered person, including Preventive, Basic, Major, and Orthodontia Care, is:

- Calendar Year Maximums - $1,000.
- Orthodontia Lifetime Maximums - $1,000. Orthodontia maximums apply to Calendar Year Maximums.

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. The deductible does not apply to Preventive Care.

Covered Expenses

Covered Expenses are the Allowable Amounts payable under the Plan. Dental services must be performed by or under the supervision of a Provider and must be essential for the care of the teeth. Dental services must begin whilethe person is covered under the Plan.

A Covered Expense is considered incurred on the date when:

1. The final impression is taken for dentures and partials.
2. Fixed bridgework, crowns, inlays, and onlays are prepared to receive the restoration.
3. The pulp chamber is opened for root canal therapy.
4. Bands and appliances are placed for Orthodontia Care.
5. Any other covered service is provided.

Preventive Care

Covered services include:

1. Routine oral examinations, limited to two per Plan Year.
2. Intraoral X-rays, limited to one series every five years.
3. Bitewing X-rays, limited to two series per Plan Year.
4. Prophylaxes (teeth cleanings), limited to two per Plan Year.
5. Fluoride Treatment limited to one per Plan Year. Covered for dependents through age 12 only.
6. Sealants. Covered for dependents through age 16 only.
7. Emergency treatment for relief of dental pain on a day for which no other benefit, other than X-rays, is payable.

Basic and Major Care

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

1. Oral Surgery, including extractions, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw.
2. Treatment of the gums and supporting structures of the teeth.
3. Root canal therapy and other endodontic treatment.
4. General anesthetics and their administration.
5. Antibiotics and therapeutic injections administered by a Provider.
6. Restorations for teeth broken down by decay or Injury.

Limitations

1. Services provided must be necessary for:
    - Preventive care.
    - Treatment of dental disease or defect.
    - Treatment of an Injury.
2. Covered services for gold restorations and prosthetic services are limited to:
    - Repair and rebasing of existing dentures that have not been replaced by a new denture.
    - Full or partial dentures, fixed bridges, or the addition of teeth to an existing denture.
3. Services of a Dental Hygienist are covered only if the Dental Hygienist is working under the supervision of a Provider.

4. Oral exams are Covered Expenses only when service is not duplicated by another procedure performed on the same day.
5. Orthodontia Care-eligible expenses are reimbursed at 100% of the allowable amount for In-Network providersand up to the Table of Allowance for Out-of-Network providers, as work progresses and as the receipts are submitted.
6. 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 stay plate, 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.

Expenses Not Covered

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

1. Expenses in excess of the amounts listed in the Table of Allowances for the Plan or in excess of the frequency limitations.
2. Expenses in excess of the Plan Calendar Year or Orthodontia Lifetime Maximums.
3. Services performed for cosmetic reasons, except to correct a congenital anomaly of a Dependent child under 19 years of age.
4. Replacement of missing, lost, or stolen appliances.
5. Replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability.
6. 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.
7. Dental procedures covered by one of the medical benefit plans sponsored by the City.
8. Work-related illness, injury, or complication thereof, arising out of the course of employment.
9. 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.
10. Appliances or restorations, other than full dentures, whose primary purpose is to alter vertical dimension, stabilize periodontally involved teeth, or restore occlusion.
11. Crowns for teeth restorable by other means, or for the purpose of periodontal splinting.
12. Drugs or medications other than antibiotic drug injections.
13. Bite registration or analysis.
14. Instruction, planning, or training services performed for problems associated with diet, oral plaque control, or preventive dental care.
15. Precision or semi-precision instruments.
16. Implants and related services, except implant supported prosthetics.
17. Transplants.
18. Denture duplication.
19. Overdentures.
20. Charges incurred for missed appointments.
21. Night guards.
22. Splints.
23. Dental services that do not have uniform dental endorsement.
24. Placement of bands and regular maintenance of braces, resulting from:
    - 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.

- 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.

25. Temporary restorations.
26. 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.
27. Infection control fees.
28. Charges assessed by the Provider for the completion of a claim form.
29. Services provided by any government agency, whether Federal, State, County, or City.
30. Non-billed services.

Section 5 Claims Filing and Appeals Procedures

Filing of Claims Required

In-Network Providers will file your claim directly to BCBSTX for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file the claim form for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

If the Out-of-Network Provider does not file the claim on your behalf, you will need to file the claim to BCBSTX using a Participant-filed claim form provided by BCBSTX. You can obtain a Dental Claim Form from the BCBSTX website at www.bcbstx.com/coa. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the Provider printed on their letterhead and show the:

1. services performed;
2. dates of service;
3. charges; and
4. name of the Participant involved

Visit the BCBSTX Website for Dental Claim Forms and Other Useful Information at: www.bcbstx.com/coa

Mail completed Forms to: Blue Cross and Blue Shield of Texas
Dental Claims Division
P.O. Box 660247
Dallas, Texas 75266-0247

Who Receives Payment

Benefit payments will be made directly to the Providers when they bill the claim to BCBSTX. Written agreements between BCBSTX and some Providers may require payment directly to them. Any benefits payable to you, if unpaidat your death, will be paid to your beneficiary or to your estate, if no beneficiary is named.

Except as provided in the **Assignment and Payment of Benefits** section, rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator Benefits for services provided to your minor Dependent child may be paid to a third party if:

- Third party is named in a Court Order as managing or possessory conservator of the child; and
- BCBSTX has not already paid any portion of the claim.

For benefits to be payable to a managing or possessory conservator of a child, the conservator must submit to BCBSTX, with the claim form, proof of payment of the expenses and a certified copy of the Court Order naming that person the managing or possessory conservator.

BCBSTX may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by BCBSTX from benefit payments of amounts owed to BCBSTX, will be considered in satisfaction of its obligations to you under the Plan.

An Explanation of Benefits (EOB) for Dental Care summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Plan must be properly submitted within 90 days after the date you receive the services or supplies. Claims not submitted and received by BCBSTX within 90 days do not invalidate or reduce a claim if:

- It was not reasonably possible to provide the claim within that time;
- The claim is provided as soon as reasonably possible; and
- Unless the claimant does not have the legal capacity to provide it, the claim is provided not later than twelve (12) months after that date the claim is otherwise required.

Receipt of Claims BCBSTX

A claim will be considered received by BCBSTX for processing upon actual delivery to BCBSTX's Administrative Office in the proper manner and form and with all the information required. If the claim is not complete, it may be denied, or BCBSTX may contact either you or the Provider for the additional information.

Review of Claim Determination

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority under the Plan to interpret and determine benefits in accordance with the Plan provisions. BCBSTX will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between BCBSTX and the Plan Administrator.

After processing the claim, BCBSTX will notify the Participant by way of an EOB for Dental Care.

If a Claim Is Denied or Not Paid in Full

If the claim is denied in whole or in part, you will receive a written notice from BCBSTX with the following information, if applicable:

1. The reasons for the determination;
2. A reference to the benefit Plan provisions on which the determination is based;
3. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
4. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings. Upon request, treatment codes with their meanings and the standards used are also available;
5. An explanation of BCBSTX's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's dental circumstances, if the denial Experimental/Investigational treatment was based on Dental Necessity, or similar exclusion, or a statement that such explanation will be provided free of charge upon request; and

9. Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are two types of claims as defined below.

1. Pre-Service Claim is any request for benefits or a determination with respect to which the terms of the benefit Plan condition receipt of the benefit on approval of the benefit in advance of obtaining dentalcare.
2. Post-Service Claim is notification in a form acceptable to BCBSTX that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the claim charge, and any other information which BCBSTX may request in connection with services rendered to you.

Dental Claims

Type of Notice or Extension	Timing
If your claim in incomplete, BCBSTX must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claim Administrator within:	**45 days after receiving notice**
BCBSTX must notify you of any adverse claim determination:	
If the initial claim is complete, within:	**30 days**
After receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

This period may be extended one time by BCBSTX for up to 15 days, provided that BCBSTX both: (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which BCBSTX expects to render a decision.

Claim Appeal Procedures

Claim Appeal Procedures

An “Adverse Benefit Determination” means a denial, reduction, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, or failure to provide in response to a claim, Pre-Service Claim, or make payment for, a benefit resulting from the application utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Dentally Necessary or appropriate. If an ongoing Course of Treatment had been approved by BCBSTX and BCBSTX reduces such treatment (other than by amendment or termination of the Employer's benefit Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by BCBSTX in accordance with the benefits and procedures detailed in your Plan. An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a dental care Provider may appeal on their own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call BCBSTX at the number on the back of your Identification Card. If you believe BCBSTX incorrectly denied all or part of your benefits, you may have your claim reviewed. BCBSTX will review its decision in accordance with the following procedure:

1. Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to BCBSTX to request a claim review. If the appeal is made orally, BCBSTX will acknowledge the request in writing and include a one-page appeal form sent to the appealing party. BCBSTX will need to know the reasons why you do not agree with the Adverse Benefit Determination.
   Send your request to: Dental Claim Review Section, Blue Cross and Blue Shield of Texas, P.O. Box 660247, Dallas, Texas 75266-0247
2. BCBSTX will honor telephone requests for information; however, such inquiries will not constitute a request for review. Any complaint concerning dissatisfaction or disagreement with an Adverse Benefit Determination constitutes an appeal.
3. In support of your claim review, you have the option of presenting evidence and testimony to BCBSTX. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional dental information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

BCBSTX will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. If the initial benefit determination regarding the claim is based in whole or in part on a dental judgment, the appeal determination will be made by a Provider associated or contracted with BCBSTX ~~a~~nd/or by external advisors, but who were not involved inmaking the initial denial of your claim.

If you have any questions about the claims procedures or the review procedure, write to BCBSTX Administrative Office or call **888-907-7880**.

Timing of Appeal Determinations

BCBSTX will render a determination on an appeal of an Adverse Benefit Determination as soon as possible but not later than 30 days after the appeal has been received by BCBSTX.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call BCBSTX at **888-907-7880**. The BCBSTX Customer Service is available from 8:00 a.m. to 6:00 p.m., Monday through Friday.

Dental Claim Review Section Blue Cross and Blue Shield of Texas, P. O. Box 660247, Dallas, Texas 75266-0247

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may call **888-907-7880**. In addition, for questions about your appeal rights or for assistance, you can call the Employee Benefits Security Administration at **866-444-EBSA** (3272).

Notice of Appeal Determination

BCBSTX will notify the party filing the appeal, you, and, if a clinical appeal, any dental care Provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice to you or your authorized representative will include:

1. The reasons for the determination;
2. A reference to the benefit Plan provisions on which the determination is based;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, treatment codes with their meanings are also available;
4. An explanation of BCBSTX external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

6. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
7. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and
8. Contact information for applicable office of health insurance consumer assistance or ombudsman.

If BCBSTX denies your appeal, in whole or in part, or you do not receive a timely decision, you have the right to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in **the How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)** section below.

How To Appeal A Final Internal Adverse Determination to an Independent Review Organization (IRO)

An "**Adverse Determination**" means a determination by BCBSTX or its designated utilization review organization that a dental care service that is a covered service has been reviewed and, based upon the information provided, is determined to be Experimental/Investigational, or does not meet BCBSTX's requirements for Dental Necessity, or appropriateness and the requested service or payment for the service is therefore denied or reduced

A "Final Internal Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by BCBSTX at the completion of BCBSTX's internal review/appeal process.

This procedure (not part of the complaint process) pertains only to appeals of Adverse Determinations.

Any party whose appeal of an Adverse Determination is denied by BCBSTX may seek review of the decision by an IRO. At the time the appeal is denied, BCBSTX will provide you, your designated representative or Provider of record, information on how to appeal the denial, including the approved form, which you, your designated representative, or your Provider of record must complete.

1. BCBSTX will submit dental records, names of Providers and any documentation pertinent to the decision of the IRO.
2. BCBSTX will comply with the decision by the IRO.
3. BCBSTX will pay for the independent review.

Upon request and free of charge, you or your designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or appeal, including:

1. Information relied upon to make the decision;
2. Information submitted, considered or generated in the course of making the decision, whether it was relied upon to make the decision;
3. Descriptions of the administrative process and safeguards used to make the decision;
4. Records of any independent reviews; conducted by BCBSTX;
5. Dental judgments, including whether a service is; Experimental/Investigational or not Dentally Necessary or appropriate; and
6. Expert advice and consultation obtained by BCBSTX in connection with the denied claim, whether the advice was relied upon to make the decision.

The appeal process does not prohibit you from pursuing other appropriate remedies, including injunctive relief; a declaratory judgment or other relief available under law. If your Plan is governed by the Employee Retirement Income Security Act (ERISA), you have the right to bring civil action under 502(a) of ERISA.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given BCBSTX the limited authority to process claims per the terms and conditions of the Plan and to determine benefits in accordance with the Plan's provisions.

All powers to be exercised by BCBSTX or the Plan Administrator shall be exercised in a non- discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Actions Against Blue Cross Blue Shield of Texas

No lawsuit or action in law or equity may be brought by you or on your behalf prior to the expiration of 60 days after Proof of Loss has been filed in accordance with the requirement of the Plan and no such action will be brought at all unless brought within three years from the expiration of the time within which Proof of Loss is required by the Plan.

Section 6 General Provisions

Agent

The Employer is not the agent of BCBSTX.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and BCBSTX.

Assignment and Payment of Benefits

If a written assignment of benefits is made by a Participant to a Provider and the written assignment is delivered toBCBSTX with the claim for benefits, BCBSTX will make any payment directly to the Provider, Payment to the Provider discharges BCBSTX's responsibility to Participant for any benefits available under the Plan.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any Provider, insurance carrier, or other entityto furnish BCBSTX all information and records or copies of records relating to the diagnosis, treatment, or care ofany individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Participant/Provider Relationship

The choice of a Provider should be made solely by you or your Dependents. BCBSTX does not furnish services or supplies but only makes payment for Eligible Dental Expenses incurred by Participants. BCBSTX is not liable forany act or omission by any Provider. BCBSTX does not have any responsibility for a Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the Provider selected and are available only for treatment acceptable to the Provider.

Refund of Benefit Payments

If BCBSTX pays benefits for Eligible Dental Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, BCBSTX has the right to a refund from the Participant to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, BCBSTX may deduct any refund due to them from any future benefit payment.

Reimbursement

When BCBSTX pays benefits under the Plan and it is determined that a negligent third party is liable for the same expenses, BCBSTX has the right to receive reimbursement from the monies payable from the negligent third party equal to the amount BCBSTX has paid for such expenses. The Participant hereby agrees to reimburse BCBSTX from any monies recovered from a negligent third party as a result of a judgment against, settlement with, or otherwise paid by the third party. The Participant agrees to act against the third party, furnish all information, and provide assistance to BCBSTX regarding the action taken, and execute and deliver all documents and information necessary for BCBSTX to enforce our rights of reimbursement.

BCBSTX's process to recover by subrogation or reimbursement will be conducted in accordance with Texas Civil Practice and Remedies Code Title 6, Chapter 140.

Coordination of Benefits

The availability of benefits specified in This Plan is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has health/dental care coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

Plan means any group insurance or group-type coverage, whether insured or uninsured.

This includes:

- Group or blanket insurance;
- Franchise insurance that terminates upon cessation of employment;
- Group hospital or medical/dental service plans and other group prepayment coverage;
- Any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
- Governmental plans, or coverage required or provided by law.

This does not include:

- Any coverage held by the Participant for hospitalization, dental and/or medical- surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- A policy of health insurance that is individually underwritten and individually issued;
- School accident type coverage; or
- A state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

1. This Plan means the part of this Benefit Booklet that provides benefits for health/dental care expenses.
2. Primary Plan/Secondary Plan
3. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A Primary Plan is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A Secondary Plan is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.
4. When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.
5. Allowable Expense means a necessary, reasonable, and customary item of expense for health/dental care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.
6. **Claim Determination Period** means a Plan Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
7. **We** or **Us** means BCBSTX.

Order of Benefit Determination Rules

General Information

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules coordinating its benefits with those of This Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

Rules

This Plan determines its order of benefits using the first of the following rules which applies:

1. **Non-Dependent/Dependent**. The benefits of the Plan which covers the Participant as an Employee or retiree, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

    - Secondary to the Plan covering the Participant as a Dependent; and
    - Primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than as a Dependent.

2. **Dependent Child/Parents Not Separated or Divorced**. Except as stated in rule 3 below, when This Plan and another Plan cover the same child as a Dependent of different parents:

    - The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but
    - If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period.

However, if the other Plan does not have the rule described in this rule, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Planwill determine the order of benefits.

3. **Dependent Child/Parents Separated or Divorced.** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

    - First, the Plan of the parent with custody of the child;
    - Then, the Plan of the spouse of the parent with custody, if applicable;
    - Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health/dental care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any Plan Year during which any benefits are actuallypaid or provided before the entity has that actual knowledge.

4. **Joint Custody**. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health/dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in rule 2.

5. **Active/Inactive Employee**. The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.

6. **Continuation Coverage**. If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

    a. First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);

    b. Second, the benefits under the continuation coverage.

7. **Longer/Shorter Length of Coverage**. If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. When This Section Applies

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. Reduction in this Plan's Benefits

The benefits of This Plan will be reduced when the sum of:

- The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether claim is made exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, we may recover the excess from one or more of:

- the persons we have paid or for whom we have paid;
- insurance companies; or
- Hospitals, physicians, or other Providers; or
- any other person or organization.

Termination of Coverage

BCBSTX is not required to give you prior notice of termination of coverage. BCBSTX will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage

Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your contribution for coverage under the Plan is not received timely by BCBSTX; or
2. You no longer satisfy the definition of an Employee or retiree as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

Coverage for a child of any age who is medically certified as Disabled and dependent on you will not terminate upon reaching the limiting age shown in the definition of Dependent if the child continues to be both:

- Disabled; and
- Dependent upon you for support and maintenance as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age.

Termination of the Group

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

If such an event occurs, you or your Dependents should immediately contact your Employer to determine your rights.

If the occurrence of the event requires coverage to terminate and if there is a right to continue the group coverage, the election to do so must be made within a prescribed time period. You or your Dependents may be required to pay your own premium rates. Any continued coverage will be identical to that of similarly situated members of the group, including any changes (see your Dental Schedule of Coverage). Hence, changes in the group premium rates or benefits will change the premium rates or benefits for any continued coverage.

The continued coverage automatically terminates after a period of time (never to exceed three years) but will be terminated earlier upon the occurrence of certain circumstances. These circumstances include, but are not limited to, nonpayment of premium, entitlement to or coverage under Medicare and coverage under any other group health coverage which does not contain a limitation with respect to a preexisting condition of the Participant (even if such coverage is less valuable than your current health plan). Your Employer will give you more detailed information upon your request.

Information Concerning Employee Retirement Income Security Act of 1974 (ERISA)

1. If the Plan is part of an "employee welfare benefits plan" and "welfare plan" as those terms are defined in ERISA:
2. BCBSTX will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Plan. Upon written request by the Plan Administrator, BCBSTX will send any information which BCBSTX has that will aid the Plan Administrator in making its annual reports.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Plan. Claim filing and claim review procedures are found in the CLAIM FILING AND APPEALS PROCEDURES section of this Benefit Booklet.
4. BCBSTX is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Plan.
5. This Benefit Booklet is not a summary plan description.
6. The Plan Administrator has given BCBSTX the limited authority to process claims per the terms and conditions of the Plan and to determine benefits in accordance with the Plan's provisions. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Plan's provisions and determining

questions of eligibility and benefit design. Any decisions regarding eligibility and benefit design made by the Plan Administrator shall be final and conclusive. Plan Administrator delegated to BCBSTX limited authority to administer claims in accordance with the terms of the Plan's provisions and to make initial claim determinations and benefit determinations for appealed claims.

Section 7 Plan Administration Information

Plan Administrator

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

Claim Administrator

Blue Cross and Blue Shield of Texas
888-907-7880
Website: www,bcbstx.com/coa

Section 8 Dental Plan Document Definitions

Allowable Amount

The maximum amount determined by BCBSTX to be eligible for consideration of payment for a service, supply or procedure.

- For Providers contracting with BCBSTX.
- The Allowable Amount is based on the terms of the Provider's contract and BCBSTX's methodology ineffect on the date of service.
- Out-of-Network Providers with BCBSTX.
- The Allowable Amount is based on the amount BCBSTX would have paid for the same covered service, supply, or procedure if performed or provided by in-Network Provider.
- Unless otherwise stipulated by a contract between the Provider and BCBSTX:
- For services performed in Texas – the Allowable Amount is based upon the applicable methodology for Providers with similar experience and/or skills.
- For services performed outside of Texas – the Allowable Amount will be established by identifying Providers with similar experience or skills in order to establish the applicable amount for the procedure,services, or supplies.
- For multiple surgical procedures performed in the same operative area – the Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.
- When a less expensive professionally acceptable service, supply, or procedure is available The Allowable Amount will be based upon the least expensive services. This is not a determination of Dental Necessity, but merely a contractual benefit allowance.

Claim Administrator

BCBSTX, as part of its duties as Claim Administrator, may subcontract portions of its responsibilities.

Contracting Provider

A Provider who has entered into a written agreement with BCBSTX to participate as a BlueCare Dental Provider. SeeIn-Network.

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.

Court Order
A direction issued by a court or a judge requiring a Participant to do or not do something. A Court Order may also include an administrative order.

Coverage
Benefits under the BlueCare Dental PPO Plan.

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 for the covered procedure/service. The Deductible does not apply to Preventive Care.

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.

Dentally Necessary
Those services, supplies, or appliances covered under the Plan which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury; and
- Provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
- Not primarily for the convenience of the Participant or his Provider; and
- The most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Participant.

BCBSTX shall determine whether a service, supply, or appliance is Dentally Necessary and will consider the views of the state and national health communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Provider may have prescribed treatment, such treatment may not be Dentally Necessary within this definition.

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

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.

Diagnostic
The necessary procedures to assist the Provider in evaluating the covered person's conditions and the dental carerequired.

Endodontics
The necessary procedures for pulpal and root canal surgery.

Explanation of Benefits (EOB)
A statement provided by BCBSTX to you, your Physician, or another health care professional that explains:

1. The Benefits provided, if any.
2. The allowable reimbursement amounts.
3. Deductibles.
4. Coinsurance.
5. Any other reductions taken.
6. The net amount paid by the Plan.
7. The reason(s) why the service or supply was not covered by the Plan.

Identification Card
The card issued to the retiree by BCBSTX indicating pertinent information applicable to his coverage.

In-Network Providers
Providers who have signed an agreement with BCBSTX to accept the Allowable Amount as payment in full. Such Participating Providers have agreed not to bill you for Covered Service amounts in excess of the Allowable Amount.Therefore, you will be responsible only for your Calendar Year deductible, if it has not already been satisfied.

Injury
A bodily injury resulting from a traumatic event or extreme exposure to the elements which requires treatment by a Provider. 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.

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

1. Cleft palate.
2. Cross bite.
3. Congenitally missing permanentteeth.
4. Impacted teeth other than third molars.
5. Overjet.
6. Overbite.
7. Crowding.
8. Open bite.

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

Orthodontia Care
The movement of teeth to correct a Malocclusion pursuant to a Dental Treatment Plan approved by BCBSTX.

Out-of-Network Providers
Providers who have not signed an agreement with BCBSTX to accept the Allowable Amount as payment in full. Therefore, you are responsible to these Providers for the difference between the allowed amount on the Table of Allowances and such Provider's charge to you.

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

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

Plan Administrator
The City of Austin or its designee.

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

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

Provider
A Provider or any other person, company, or institution furnishing to a Participant, when acting within their scope oftheir license, an item of service or supply listed as an Eligible Dental Expenses.

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 Provider.

Information Provided by Your Employer

Retiree City of Austin
Out-of-Network Table of Allowances

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 (Once every 5 years)	$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 (Twice a year)	$34.15
D0272	Bitewings: 2 Radiographic Images (Twice a year)	$54.64
D0273	Bitewings: 3 Radiographic Images (Twice a year)	$66.60
D0274	Bitewings: 4 Radiographic Images (Twice a year)	$76.84
D0277	Vertical Bitewings: 7 to 8 Radiographic Images (Twice a year)	$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 Transepithelial 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
D1206	Topical application of fluoride varnish:	$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

ADA CODE	Preventive Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
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
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	$1,000.00
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	$1,000.00
D3348	Retreatment of Previous Root Canal Therapy, Molar	$1,000.00
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)	$1,000.00
D3425	Apicoectomy, Molar (First Root)	$1,000.00
D3426	Apicoectomy, each Additional Root	$392.26
D3428	Bone Graft in Conjunction with Periradicular Surgery – per Tooth, First Site	$1,000.00
D3429	Bone Graft in Conjunction with Periradicular Surgery – each Additional Contiguous Tooth in Same Surgical Site	$1,000.00
D3430	Retrograde Filling, per Root	$288.19
D3431	Biological Materials to Aid in Soft and Osseous Tissue Regeneration in Conjunction with Periradicular Surgery	$1,000.00

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D3432	Guided Tissue Regeneration, Resorbable Barrier, per Site in Conjunction with Periradicular Surgery	$1,000.00
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
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	$1,000.00
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	$1,000.00
D4273	Autogenous Connective Tissue Graft Procedures (First Tooth)	$1,000.00
D4275	Non-Autogenous Connective Tissue Graft Procedure (First Tooth)	$931.78
D4276	Combined Connective Tissue and Pedicle Graft, perTooth	$1,000.00
D4277	Free Soft Tissue Graft (First Tooth)	$1,000.00
D4278	Free Soft Tissue Graft, each Additional Tooth	$345.66
D4283	Autogenous Connective Tissue Graft Procedure, each Additional Tooth	$1,000.00
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
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

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
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 (Direct)	$368.01
D5731	Reline Complete Mandibular Denture (Direct)	$368.01
D5740	Reline Maxillary Partial Denture (Direct)	$337.22
D5741	Reline Mandibular Partial Denture (Direct)	$337.22
D5750	Reline Complete Maxillary Denture (Indirect)	$491.16
D5751	Reline Complete Mandibular Denture (Indirect)	$491.16
D5760	Reline Maxillary Partial Denture (Indirect)	$483.83
D5761	Reline Mandibular Partial Denture (Indirect)	$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

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
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
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	$1,000.00
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	Alveoloplasty with Extractions, 4 or more Teeth or Tooth Spaces, per Quadrant	$309.80
D7311	Alveoloplasty in Conjunction with Extractions, 1 to 3 Teeth or Tooth Spaces, per Quadrant	$271.07
D7320	Alveoloplasty without Extractions, 4 or more Teeth or Tooth Spaces, per Quadrant	$503.42

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D7321	Alveoloplasty Not in Conjunction w/Extractions, 1 to 3 Teeth or Tooth Spaces, per Quadrant	$425.97
D7340	Vestibuloplasty, Ridge Extension (secondary epithelization)	$1,000.00
D7350	Vestibuloplasty, Ridge Extension (with soft tissue graft)	$1,000.00
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
D7961	Buccal/labial frenectomy (Frenulectomy)	$425.97
D7962	Lingual Frenectomy (Frenulectomy)	$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
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

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D2663	Onlay: Composite/Resin, 3 Surfaces	$455.38
D2664	Onlay: Composite/Resin, 4 or more Surfaces	$487.91
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
D2928	Prefabricated Porcelain/Ceramic Crown – Permanent Tooth	$232.20
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
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) Direct	$466.00
D2961	Labial Veneer (resin laminate) Indirect	$528.67
D2962	Labial Veneer (porcelain laminate) Indirect	$574.46
D2971	Additional Procedures to Customize a Crown Under an 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

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D2983	Veneer Repair Necessitated by Restorative Material Failure	$112.48
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	$40.17
D5110	Complete Denture, Maxillary	$1,000.00
D5120	Complete Denture, Mandibular	$1,000.00
D5130	Immediate Denture, Maxillary	$1,000.00
D5140	Immediate Denture, Mandibular	$1,000.00
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	$1,000.00
D5214	Mandibular Partial Denture, Cast Metal Framework with Resin Denture Bases	$1,000.00
D5221	Immediate Maxillary Partial Denture Resin Base	$924.60
D5222	Immediate Mandibular Partial Denture Resin Base	$1,000.00
D5223	Immediate Maxillary Partial Denture Cast Metal Framework	$1,000.00
D5224	Immediate Mandibular Partial Denture Cast Metal Framework	$1,000.00
D5225	Maxillary Partial Denture: Flexible Base (including retentive/clasping materials, rests and teeth)	$847.62
D5226	Mandibular Partial Denture: Flexible Base (including retentive/clasping materials, rests and teeth)	$985.08
D5282	Removable Unilateral Partial Denture: One Piece Cast Metal, (including retentive/clasping materials, rests and teeth), Maxillary	$646.94
D5283	Removable Unilateral Partial Denture: One Piece Cast Metal, (including retentive/clasping materials, rest and teeth), Mandibular	$646.94
D5284	Removable Unilateral Partial Denture: One Piece Flexible Base, (including retentive/clasping materials, rests and teeth) - per Quadrant	$510.15
D5286	Removable Unilateral Partial Denture: One Piece Resin (include retentive/clasping materials, rests and teeth) per Quadrant	$556.32
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

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLEAMOUNT
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
D6086	Implant Supported Crown: Predominantly Base Alloys	$797.22
D6087	Implant Supported Crown: Noble Alloys	$833.88
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

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
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	$1,000.00
D6111	Implant/Abutment Supported Removable Denture for Edentulous Arch, Mandibular	$1,000.00
D6112	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch, Maxillary	$1,000.00
D6113	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch, Mandibular	$1,000.00
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
D6214	Pontic - Tatanium and titanium Alloys	$662.52
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

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
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
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
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, per Tooth	$66.29

Orthodontia Care:

$1,000 Orthodontia Lifetime Maximum, applied toward Calendar Year Maximum.

ADA CODE	Orthodontia Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
D0470	Diagnostic Casts	$65.51
D1510	Space Maintainer: Fixed Unilateral, per Quadrant, Excludes a Distal Shoe	$202.35
D1516	Space Maintainer: Fixed Bilateral, Maxillary	$283.29
D1517	Space Maintainer: Fixed Bilateral, Mandibular	$283.29
D1520	Space Maintainer: Removable Unilateral, per Quadrant	$222.59
D1526	Space Maintainer: Removable Bilateral, Maxillary	$344.00
D1527	Space Maintainer: Removable Bilateral, Mandibular	$344.00
D1551	Recement or Re – Bond Bilateral Space Maintainer, Maxillary	$43.71
D1552	Recement or Re – Bond Bilateral Space Maintainer, Mandibular	$43.71
D1553	Recement or Re – Bond Unilateral Space Maintainer, per Quadrant	$43.71
D1556	Removal of Fixed Unilateral Space Maintainer, per Quadrant	$42.09
D1557	Removal of Fixed Bilateral Space Maintainer, Maxillary	$42.09
D1558	Removal of Fixed Bilateral Space Maintainer, Mandibular	$42.09
D1575	Distal Shoe Space Maintainer: Fixed Unilateral, per Quadrant	$221.45
D8010-D8090	Initial Insertion of Appliances	$750.00
D8210	Removable Appliance Therapy	$100.00
D8220	Fixed Appliance Therapy	$100.00
D8660	Pre-Orthodontic Treatment Visit	$30.92
D8670	Periodic Orthodontic Treatment Visit	$150.00
D8695	Removal of Fixed Orthodontic Appliance for Reasons Other than Completion of Treatment	$50.00
D8696	Repair of Orthodontic Appliance, Maxillary	$80.96
D8697	Repair of Orthodontic Appliance, Mandibular	$80.96
D8889	Ortho Diagnostic Records, Study Model	$50.00
D8680	Orthodontic Retention: Removal of Appliance, Placement of Retainer	$327.20

NOTICES

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his
- or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part
- A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or

- The child stops being eligible for coverage under the Plan as a “dependent child.”

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at: www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Administered by:

BlueCross BlueShield
Of Texas