City of Austin

2017

Employee Dental Assistance Plan Document

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Helpful Resources

City of Austin Human Resources Department

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

Phone number: **512-974-3284**
TTY number: 512-974-2445; Relay Texas: 800-735-2989
Fax number: 512-974-3420

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

Call for: Enrollment and adding/dropping dependents

CompuSys/Erisa Group, Inc. (Erisa)
13706 Research Blvd., Suite 308
Austin, Texas 78750

Phone number: **512-250-9397**
Toll-free number: 800-933-7472; Relay Texas: 800-735-2989
Office hours: 7:30 a.m. to 5:30 p.m., Monday – Friday

Call for: Dental coverage and claims information

To check claim status, visit coadentalplan.com

2017 Dental Plan Document

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

Section 1 Plan Provisions

This document constitutes the entire 2017 Employee Dental Assistance Plan (the Plan) for eligible City employees and their eligible dependents. The Plan does not constitute a contract of employment. Defined terms are capitalized in this document. See Section 10, Dental Plan Documents Definitions.

Section 2 Eligibility

The City will determine eligibility for covered persons enrolled in the Plan. Eligibility guidelines are outlined in the *2017 Employee Benefits Guide*.

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

(A) Dentures, if the final impressions were taken before Coverage ended.

(B) A crown, bridge, or gold filling, if the tooth was finally prepared and impressions were taken before Coverage ended.

(C) Root canal work, if the pulp chamber was opened and the canal was explored to the apex before Coverage ended.

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

Section 3 Dental Benefits

3.1 Maximum Benefits

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

(A) Calendar Year Maximums - $2,000.

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

3.2 Deductible

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

3.3 Covered Expenses

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

A Covered Expense is considered incurred on the date when:

(A) The final impression is taken for dentures and partials.

(B) Fixed bridgework, crowns, inlays, and onlays are prepared to receive the restoration.

(C) The pulp chamber is opened for root canal therapy.

(D) Bands and appliances are placed for Orthodontia Care.

(E) Any other covered service is provided.

3.3.1 Preventive Care

Covered services include:

(A) Routine oral examinations, limited to two per Plan Year.

(B) Intraoral X-rays, limited to one series every five years.

(C) Bitewing X-rays, limited to two series per Plan Year.

(D) Prophylaxes (teeth cleanings), limited to two per Plan Year.

(E) Fluoride Treatment, limited to one per Plan Year. Covered for dependents through age 12 only.

(F) Sealants. Covered for dependents through age 16 only.

(G) Emergency treatment for relief of dental pain on a day for which no other benefit, other than X-rays, is payable.

3.3.2 Basic and Major Care

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

(A) Oral Surgery, including extractions, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw.

(B) Treatment of the gums and supporting structures of the teeth.

(C) Root canal therapy and other endodontic treatment.

(D) General anesthetics and their administration.

(E) Antibiotics and therapeutic injections administered by a Dentist.

(F) Restorations for teeth broken down by decay or Injury.

3.3.3 Limitations

(A) Services provided must be necessary for:

(1) Preventive care.

(2) Treatment of dental disease or defect.

(3) Treatment of an Injury.

(B) Covered services for gold restorations and prosthetic services are limited to:

(1) Repair and rebasing of existing dentures which have not been replaced by a new denture.

(2) Full or partial dentures, fixed bridges, or the addition of teeth to an existing denture.

(C) Services of a Dental Hygienist are covered only if the Dental Hygienist is working under the supervision of a Dentist.

(D) Oral exams are Covered Expenses only when service is not duplicated by another procedure performed on the same day.

(E) Orthodontia Care-eligible expenses are reimbursed at 50% of the allowable charge as work progresses and as the receipts are submitted. Benefits for the initial insertion of appliances will be reimbursed at 50% of allowable charges up to a maximum of $500, and are included in the calendar year and Orthodontia Lifetime Maximum.

(F) Replacement of any prosthesis (bridge, denture, crown, or orthodontic appliance) within five years of City coverage after it was first placed is not covered, unless replacement is needed because of initial placement of an opposing full prosthesis or the extraction of teeth; or the prosthesis is a stayplate, or a similar temporary prosthesis, and while in the mouth, has been damaged beyond repair as a result of an Injury occurring while covered. Stolen or lost prostheses are not covered. Temporary or duplicate devices are not covered.

3.4 Expenses Not Covered

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

(A) For Expenses in excess of the amounts listed in the Table of Allowances for the Plan or in excess of the frequency limitations stated in Section 3.3.1 of the Plan.

(B) Expenses in excess of the Plan calendar year or Orthodontia Lifetime Maximums.

(C) Services performed for cosmetic reasons, except to correct a congenital anomaly of a Dependent child under 19 years of age.

(D) Replacement of missing, lost, or stolen appliances.

(E) Replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability.

(F) Expenses incurred after termination of coverage except for dental services which were initiated prior to termination, and which were delivered to the covered person within 31 days after the date of termination.

(G) Dental procedures covered by one of the medical benefit plans sponsored by the City.

(H) Work-related illness, injury, or complication thereof, arising out of the course of employment.

(I) Charges which a covered person is not required to pay, including charges for services furnished by any hospital or organization which normally makes no charge if the patient has no hospital, surgical, medical, or dental coverage.

(J) Appliances or restorations, other than full dentures, whose primary purpose is to alter vertical dimension, stabilize periodontally involved teeth, or restore occlusion.

(K) Crowns for teeth restorable by other means, or for the purpose of periodontal splinting.

(L) Drugs or medications other than antibiotic drug injections.

(M) Bite registration or analysis.

(N) Instruction, planning, or training services performed for problems associated with diet, oral plaque control, or preventive dental care.

(O) Precision or semi-precision instruments.

(P) Implants and related services, except implant supported prosthetics.

(Q) Transplants.

(R) Denture duplication.

(S) Overdentures.

(T) Charges incurred for missed appointments.

(U) Night guards.

(V) Splints.

(W) Dental services that do not have uniform dental endorsement.

(X) Placement of bands and regular maintenance of braces, resulting from:

(1) Mandibular or maxillofacial surgery to correct growth defects, jaw disproportions, or malocclusion, except for the correction of a congenital anomaly of a Dependent child under 19 years of age.

(2) Appliances or restorations used solely to increase vertical dimension, to reconstruct occlusion, or to correct or treat temporomandibular joint (TMJ) dysfunction or TMJ pain syndrome.

(Y) Temporary restorations.

(Z) Services for procedures which began prior to the effective date of Coverage under the Plan, including services for Orthodontia Care and prosthetics, if initial treatment or banding began prior to the effective date of Coverage under the Plan.

(AA) Infection control fees.

(BB) Charges assessed by the Dentist for the completion of a claim form.

(CC) Services provided by any government agency, whether Federal, State, County, or City.

(DD) Non-billed services.

Section 4 Predetermination of Benefits

(A) Predetermination is a method giving the covered person and the Dentist a better understanding of expenses payable under the Plan before services are provided.

The Third Party Administrator will use the predetermination to notify the Dentist of the benefits payable for each dental service according to the terms of the Plan.

(B) Predetermination requires a written report prepared by the attending Dentist as the result of his or her examination of the covered person and providing all of the following:

(1) The recommended treatment for the complete correction of any dental disease or injury.

(2) The period during which such recommended treatment is to be provided.

(3) The estimated cost of the recommended treatment.

Information provided to the Dentist about benefits available will remain in effect for 90 days or until the end of the Plan Year, whichever comes first. The information provided is based on claims history available when the predetermination is requested. Any actual payment under the Plan is based on claims history available when the Dental Treatment Plan is completed and the actual claim for incurred services is submitted.

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

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

Section 5 Submission of Claims

5.1 Claims

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

5.2 Limitation of Liability

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

5.3 Appeals

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

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

5.4 Payment of Benefits

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

5.5 Incapacity

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

5.6 Discharge

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

5.7 Claims Recovery

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

5.8 Effective Representations

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

5.9 Plan Termination

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

5.10 Benefits Not Subject to Alienation

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

Section 6 Coordination of Benefits

6.1 Effect of Coverage under Other Plans

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

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

6.2 Order of Benefits

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

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

(B) When the other plan does have a Coordination of Benefits provision, the following rules govern:

(1) The plan which covers the covered person as an employee must determine its benefits first.

(2) If (B)(1) does not apply, the plan which covers the dependent child of the parent who is born earlier in the year (year of birth is not taken into account) will determine its benefits first, EXCEPT when a claim is made for a dependent child of divorced or separated parents, the following rules will apply:

(a) A plan which covers a child as a dependent of a parent who, by court order, must provide health coverage, will determine its benefits first.

(b) When there is no court order which requires a parent to provide health coverage to a dependent child, the following rules apply:

(i) When a parent who has custody of the child has not remarried, the custodial parent's plan will determine its benefits first.

(ii) When a parent who has custody of the child has remarried:

A. The custodial parent's plan will determine its benefits first.

B. The stepparent's plan will determine its benefits next.

C. The plan of the parent without custody will determine its benefits third.

(iii) If none of the above rules apply, the plan which has covered the dependent child for a longer period of time will determine its benefits first.

(C) Where part of the other plan coordinates benefits and a part does not, each part will be treated as a separate plan.

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

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

6.3 Right to Receive and Release Information

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

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

6.4 Payment to Third Party

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

6.5 Subrogation (Third Party Recovery)

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

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

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

(B) The Third Party Administrator will be entitled to institute an action in the name of such covered person or to join in an action brought by such covered person against such third party and to participate in any judgment, award, or settlement to the extent of its interest.

(C) Such covered person will execute such instruments which are necessary for the Plan Administrator to protect its right of subrogation and will refrain from taking any such action which may prejudice the Plan's right of subrogation. Payment by the Plan of any benefits prior to, or without obtaining signed subrogation reimbursement agreement(s), shall not operate as a waiver of this subrogation right. The subrogation reimbursement agreement(s) shall be in a form prescribed by the Plan Administrator.

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

Section 7 Plan Administration Information

7.1 Plan Administrator

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

7.2 Third Party Administrator

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

Section 8 Adoption of Plan

The foregoing provisions are hereby designated as the City of Austin Employee Dental Assistance Plan, and the provisions contained in this Plan are the basis for the administration of the employee benefit program described in this document.

The Dental Plan Document is effective January 1, 2017.

Section 9 ADA Requirements

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

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

Section 10 Dental Plan Document Definitions

10.1 Course of Treatment

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

10.2 Coverage

Benefits under the Employee Dental Assistance Plan.

10.3 Deductible

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

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

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

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

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

10.8 Endodontics
The necessary procedures for pulpal and root canal surgery.

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

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

(A) Cleft palate.

(B) Cross bite.

(C) Congenitally missing permanent teeth.

(D) Impacted teeth other than third molars.

(E) Overjet.

(F) Overbite.

(G) Crowding.

(H) Open bite.

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

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

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

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

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

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

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

10.18 Third Party Administrator
The organization responsible for processing payment of dental claims.

Section 11 2017 Table of Allowances

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

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

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

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

Preventive Care:

ADA CODE	Preventive Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
0120	Periodic Oral Evaluation	51.10
0140	Limited Oral Evaluation: Problem Focused	85.67
0145	Oral Evaluation for a Patient <3 years of age; counseling with primary caregiver	79.66
0150	Comprehensive Oral Evaluation	90.18
0160	Detailed and Extensive Oral Evaluation: Problem Focused	180.36
0170	Re-valuation: Limited Problem Focused (established patient, not post-operative)	60.12
0171	Re-valuation: Post-Operative Office Visit	66.82
0180	Comprehensive Periodontal Evaluation	97.70
0210	Intraoral: Complete Series of Radiographic Images	136.94
0220	Intraoral: Periapical first Radiographic Image	27.39
0230	Intraoral: Periapical each additional Radiographic Image	24.65
0240	Intraoral: Occlusal Radiographic Image	42.45
0250	Extraoral: 2D Projection Radiographic Image	52.04
0251	Extraoral: Posterior Dental Radiographic Image	54.44
0270	Bitewings: Single Radiographic Image	29.10
0272	Bitewings: 2 Radiographic Images	46.56
0273	Bitewings: 3 Radiographic Images	56.74
0274	Bitewings: 4 Radiographic Images	65.47
0277	Vertical Bitewings: 7 to 8 Radiographic Images	98.94
0290	Posterior/Anterior or Lateral Skull and Facial Bone Survey Radiographic Image	143.98
0310	Sialography	359.95
0330	Panoramic Radiographic Image	111.58
0340	Cephalometric Radiographic Image	125.98
0350	Oral/Facial Images, Obtained Intraorally or Extraorally	59.99
0351	3D Photographic Image	68.30
0415	Collection of Microorganisms for Culture and Sensitivity	41.92
0425	Caries Susceptibility Tests	36.14
0431	Adjunctive Pre-Diagnostic Test that Aids in Detection of Mucosal Abnormalities	48.68
0460	Pulp Vitality Tests	57.82
0486	Accession of Trasepithelial Cytologic Sample, Microscopic Examination and Written Report	138.77
1110	Prophylaxis (teeth cleaning): Adult	97.19
1120	Prophylaxis (teeth cleaning): Through age 12	67.08
1206	Topical application of fluoride varnish: Through age 12	53.42
1208	Topical application of fluoride: Through age 12	35.62
1351	Sealants per Tooth: Through age 16	52.75
1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient-Permanent Tooth	67.63
1353	Sealant Repair – per Tooth	75.42
4910	Periodontal Maintenance Procedure (following active therapy)	151.15
9110	Palliative (emergency) Treatment of Dental Pain: Minor	122.24
9310	Consultation (diagnostic service by Dentist other than requesting dentist)	199.44
9430	Office Visit for Observation (regular hours, no other services)	66.90
9910	Application of Desensitizing Medicament	72.44
9911	Application of Desensitizing Resin for Cervical and/or Root Surface, per Tooth	101.41
9951	Occlusion Adjustment, Limited	175.92
9952	Occlusion Adjustment, Complete	827.86

Basic Care:

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
2140	Amalgam (silver filling): 1 Surface	136.08
2150	Amalgam (silver filling): 2 Surfaces	176.10
2160	Amalgam (silver filling): 3 Surfaces	212.92
2161	Amalgam (silver filling): 4 or more Surfaces	259.35
2330	Resin: 1 Surface, Anterior	130.86
2331	Resin: 2 Surfaces, Anterior	167.00
2332	Resin: 3 Surfaces, Anterior	204.39
2335	Resin: 4 or more Surfaces, Anterior	241.78
2390	Resin-Based Composite Crown: Anterior	267.95
2391	Resin: 1 Surface, Posterior	153.29
2392	Resin: 2 Surfaces, Posterior	200.65
2393	Resin: 3 Surfaces, Posterior	249.26
2394	Resin: 4 or more Surfaces, Posterior	305.34
3110	Pulp Cap, Direct (excluding final restoration)	76.65
3120	Pulp Cap, Indirect (excluding final restoration)	61.32
3220	Therapeutic Pulpotomy, Remove Pulp and Apply Medications	157.14
3221	Pulpal Debridement: Primary and Permanent Teeth	172.47

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
3222	Partial Pulpotomy for Apexogeneis Permanent Tooth	159.69
3230	Pulpal Therapy: Anterior, Primary Tooth (excluding final restoration)	159.34
3240	Pulpal Therapy: Posterior, Primary Tooth (excluding final restoration)	196.11
3310	Anterior Root Canal (excluding final restoration)	625.09
3320	Bicuspid Root Canal (excluding final restoration)	766.05
3330	Molar Root Canal (excluding final restoration)	949.90
3331	Treatment of Root Canal Obstruction; Non-surgical Access	245.13
3332	Incomplete Endodontic Therapy; Inoperative, Unrestorable or Fractured Tooth	465.76
3333	Interior Root Repair of Perforation Defect	214.49
3346	Retreatment of previous Root Canal Therapy, Anterior	833.46
3347	Retreatment of previous Root Canal Therapy, Biscupid	980.54
3348	Retreatment of previous Root Canal Therapy, Molar	1213.42
3351	Apexification/Recalcification, Initial Visit	452.38
3352	Apexification/Recalcification, Interim Medication Replacement	202.79
3353	Apexification/Recalcification, Final Visit	623.97
3355	Pulpal Regeneration – Initial Visit	452.38
3356	Pulpal Regeneration – Interim Medication Replacement	202.79
3357	Pulpal Regeneration – Completion of Treatment	623.97
3410	Apicoectomy, Anterior	896.95
3421	Apicoectomy, Bicuspid (First Root)	998.35
3425	Apicoectomy, Molar (First Root)	1130.94
3426	Apicoectomy, each additional root	382.18
3427	Periradicular Surgery without Apicoectomy	811.00
3428	Bone Graft in Conjunction with Periradicular Surgery-per Tooth, First Site	1182.19
3429	Bone Graft in Conjunction with Periradicular Surgery – each Additional Contiguous Tooth in Same Surgical Site	1127.60
3430	Retrograde Filling, per Root	280.79
3431	Biological Materials to Aid in Soft and Osseous Tissue Regeneration in Conjunction with Periradicular Surgery	1388.06

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
3432	Guided Tissue Regeneration, Resorbable Barrier, per Site in Conjunction with Periradicular Surgery	1193.11
3450	Root Amputation, per Root	584.97
3920	Hemisection (including root removal) without Root Canal Therapy	444.58
3950	Canal Preparation and Fitting of Preformed Dowel or Post	202.79
4210	Gingivectomy/Gingivoplasty, 4 or more Teeth, per Quadrant	524.04
4211	Gingivectomy/Gingivoplasty, 1 to 3 Teeth, per Quadrant	232.91
4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth	200.77
4230	Anatomical Crown Exposure, 4 or more Teeth, per Quadrant	733.65
4231	Anatomical Crown Exposure, 1 to 3 Teeth, per Quadrant	349.36
4240	Gingival Flap Procedure including Root Planing, 4 or more Teeth, per Quadrant	663.78
4241	Gingival Flap Procedure including Root Planing, 1 to 3 Teeth, per Quadrant	384.29
4245	Apically Positioned Flap	489.10
4249	Clinical Crown Lengthening, Hard Tissue	727.83
4260	Osseous Surgery (including flap entry and closure), 4 or more Teeth, per Quadrant	1106.30
4261	Osseous Surgery (including flap entry and closure), 1 to 3 Teeth, per Quadrant	593.91
4263	Bone Replacement Graft, First Site in Quadrant	395.94
4264	Bone Replacement Graft, each additional site in Quadrant	337.71
4270	Pedicle Soft Tissue Graft Procedure	786.06
4273	Autogenous Connective Tissue Graft Procedures (First Tooth)	960.74
4275	Non-Autogenous Connective Tissue Graft Procedure (First Tooth)	722.01
4276	Combined Connective Tissue and Double Pedicle Graft, per Tooth	1077.19
4277	Free Soft Tissue Graft (First Tooth)	878.37
4278	Free Soft Tissue Graft, each Additional Tooth	288.61
4283	Autogenous Connective Tissue Graft Procedure, each Additional Tooth	955.92
4285	Non-Autogenous Connective Tissue Graft Procedure, each Additional Tooth	719.32
4341	Periodontal Scaling and Root Planing, 4 or more Teeth, per Quadrant	196.36

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
4342	Periodontal Scaling and Root Planing, 1 to 3 Teeth, per Quadrant	113.68
4355	Full Mouth Debridement to Enable Periodontal Evaluation and Diagnosis	134.35
5410	Adjust Complete Denture, Maxillary	74.43
5411	Adjust Complete Denture, Mandibular	74.43
5421	Adjust Partial Denture, Maxillary	74.43
5422	Adjust Partial Denture, Mandibular	74.43
5510	Repair Broken Complete Denture Base	148.87
5520	Replace Missing/Broken Teeth, complete Denture Base (each Tooth)	124.06
5610	Repair Resin Denture Base	161.27
5620	Repair Cast Framework	173.68
5630	Repair/Replace Broken Clasp	210.90
5640	Replace Broken Teeth, per Tooth	136.46
5650	Add Tooth to Existing Partial Denture	186.08
5660	Add Clasp to Existing Partial Denture per Tooth	223.30
5710	Rebase Complete Maxillary Denture	552.05
5711	Rebase Complete Mandibular Denture	527.24
5720	Rebase Maxillary Partial Denture	521.04
5721	Rebase Mandibular Partial Denture	521.04
5730	Reline Complete Maxillary Denture (chairside)	311.38
5731	Reline Complete Mandibular Denture (chairside)	311.38
5740	Reline Maxillary Partial Denture (chairside)	285.33
5741	Reline Mandibular Partial Denture (chairside)	285.33
5750	Reline Complete Maxillary Denture (lab)	415.59
5751	Reline Complete Mandibular Denture (lab)	415.59
5760	Reline Maxillary Partial Denture (lab)	409.38
5761	Reline Mandibular Partial Denture (lab)	409.38
5850	Tissue Conditioning, Maxillary	130.26
5851	Tissue Conditioning, Mandibular	130.26
5875	Modification of Removable Prosthesis following Implant Surgery	60.00
5982	Surgical Stent	552.05
6920	Connector Bar	219.87
6930	Recement Fixed Partial Denture	128.26
6940	Stress Breaker	290.71
6950	Precision Attachment	561.88
6980	Fixed Partial Denture, Repair	200.00
7111	Extraction: Coronal Remnants	112.15
7140	Extraction: Erupted Tooth or Exposed Roots	149.08

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
7210	Surgical Removal: Erupted Tooth	228.86
7220	Removal of Impacted Tooth: Soft Tissue	286.96
7230	Removal of Impacted Tooth: Partially Bony	381.83
7240	Removal of Impacted Tooth – Completely Bony	480.90
7241	Removal of Impacted Tooth: Completely Bony with Unusual Surgical Complication	563.25
7250	Surgical Removal of Residual Tooth Roots	241.90
7251	Coronectomy – Intentional Partial Tooth Removal	474.32
7260	Oroantral Fistula Closure	1407.08
7261	Primary Closure of Sinus Perforation	586.28
7270	Tooth Reimplantation and/or Stabilization	439.71
7280	Surgical Access of an Unerupted Tooth	410.40
7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	205.20
7283	Placement of Device to Facilitate Eruption of Impacted Tooth	175.89
7286	Biopsy of Oral Tissue: Soft	351.77
7288	Brush Biopsy: Transepithelial Sample Collection	140.71
7290	Surgical Repositioning of Teeth	351.77
7310	Alveoloplasty with Extractions, 4 or more Teeth or Tooth Spaces, per Quadrant	331.82
7311	Alveoloplasty in Conjunction with Extractions, 1 to 3 Teeth or Tooth Spaces, per Quadrant	290.34
7320	Alveoloplasty without Extractions, 4 or more Teeth or Tooth Spaces, per Quadrant	539.20
7321	Alveoloplasty Not in Conjunction w/Extractions, 1 to 3 Teeth or Tooth Spaces, per Quadrant	456.25
7340	Vestibuloplasty, Ridge Extension (secondary epithelization)	1800.00
7350	Vestibuloplasty, Ridge Extension (with soft tissue graft)	1800.00
7510	Incision and Drainage of Abcess, Intraoral Soft Tissue	356.70
7511	Incision & Drainage of Abcess, Intraoral Soft Tissue-Complicated (including drainage of multiple fascial spaces)	539.20
7910	Suture Recent Small Wounds, up to 5cm	544.18
7953	Bone Replacement Graft for Ridge Preservation, per Site	282.04

ADA CODE	Basic Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
7960	Frenulectomy – (Frenectomy or Frenotomy), separate procedure not incidental to another procedure	456.25
7963	Frenuloplasty	746.59
7970	Excise Hyperplastic Tissue per Arch	663.63
7971	Excise Pericoronal Gingiva	248.86
7972	Surgical Reduction of Fibrous Tuberosity	929.08
7980	Sialolithotomy	1045.22
9120	Fixed Partial Denture Sectioning	110.50
9210	Local Anesthesia not in Conjunction with Operative or Surgical Procedures	39.44
9211	Regional Block Anesthesia	43.52
9212	Trigeminal Division Block Anesthesia	67.99
9215	Local Anesthesia in Conjunction with Operative or Surgical Procedures	32.64
9219	Evaluation for Deep Sedation or General Anesthesia	85.94
9223	Deep Sedation/General Anesthesia – each 15 Minute Increment	176.78
9230	Inhalation of Nitrous Oxide/Anxiolysis Analgesia	65.27
9243	IV Conscious Sedation/Analgram – each 15 Minute Increment	149.58
9248	Non-IV Conscious Sedation	95.19

Major Care:

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
2510	Inlay: Metallic, 1 Surface	432.63
2520	Inlay: Metallic, 2 Surfaces	490.80
2530	Inlay: Metallic, 3 or more Surfaces	565.70
2542	Onlay: Metallic, 2 Surfaces	554.79
2543	Onlay: Metallic, 3 Surfaces	580.24
2544	Onlay: Metallic, 4 or more Surfaces	603.51
2610	Inlay: Porcelain/Ceramic: 1 Surface	508.98
2620	Inlay: Porcelain/Ceramic: 2 Surfaces	537.34
2630	Inlay: Porcelain/Ceramic: 3 or more Surfaces	572.24
2642	Onlay: Porcelain/Ceramic: 2 Surfaces	556.24
2643	Onlay: Porcelain/Ceramic: 3 Surfaces	599.87
2644	Onlay: Porcelain/Ceramic: 4 or more Surfaces	636.23
2650	Inlay: Composite/Resin: 1 Surface	334.47
2651	Inlay: Composite/Resin: 2 Surfaces	398.46
2652	Inlay: Composite/Resin: 3 or more Surfaces	418.82
2662	Onlay: Composite/Resin: 2 Surfaces	363.56
2663	Onlay: Composite/Resin: 3 Surfaces	427.54

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
2664	Onlay: Composite/Resin: 4 or more Surfaces	458.08
2710	Crown: Resin-based Composite (indirect)	242.97
2712	Crown: ¾ Resin-based Composite (indirect)	242.97
2720	Crown: Resin with High Noble Metal	598.87
2721	Crown: Resin with Base Metal	561.22
2722	Crown: Resin with Noble Metal	573.54
2740	Crown: Porcelain/Ceramic Substrate	614.61
2750	Crown: Porcelain fused to High Noble Metal	606.40
2751	Crown: Porcelain fused to Base Metal	564.65
2752	Crown: Porcelain fused to Noble Metal	578.33
2780	Crown: ¾ Cast High Noble Metal	581.76
2781	Crown: ¾ Predominately Base Metal	547.54
2782	Crown: ¾ Noble Metal	565.33
2783	Crown: ¾ Porcelain/Ceramic	598.18
2790	Crown: Full Cast High Noble Metal	585.18
2791	Crown: Full Cast Base Metal	554.38
2792	Crown: Full Cast Noble Metal	564.65
2794	Crown: Titanium	598.87
2910	Recement Inlay, Onlay or Partial Coverage Restoration	52.02
2915	Recement Cast or Prefabricated Post and Core	52.02
2920	Recement Crown	52.74
2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp	81.24
2929	Prefabricated Porcelain/Ceramic Crown-Primary Tooth	212.45
2930	Stainless Steel Crown: Primary Tooth	143.78
2931	Stainless Steel Crown: Permanent Tooth	162.56
2932	Prefabricated Resin Crown	173.40
2933	Prefabricated Stainless Steel Crown with Resin Window	198.69
2934	Prefabricated Esthetic Coated Stainless Steel Crown: Primary Tooth	198.69
2940	Protective Restoration	54.91
2941	Interim Therapetic Restoration-Primary Dentition	58.80
2949	Restorative Foundation for an Indirect Restoration	58.80
2950	Core Buildup (including any pins when required)	137.27
2951	Pin Retention - per Tooth Addition Restoration	31.07
2952	Post and Core in addition to Crown, Indirectly Fabricated	216.75
2953	Each additional Indirectly Fabricated Post, same Tooth	108.37
2954	Prefabricated Post and Core in addition to Crown	173.40
2955	Post Removal (not in conjunction with endodontic therapy)	133.66

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
2957	Each additional Prefabricated Post, same Tooth	86.70
2960	Labial Veneer (resin laminate) Chairside	419.05
2961	Labial Veneer (resin laminate) Lab	475.40
2962	Labial Veneer (porcelain laminate) Lab	516.58
2971	Additional Procedures to Construct New Crown Under Existing Partial Denture Framework	83.09
2975	Coping	252.87
2980	Crown Repair Necessitated by Restorative Material Failure	106.00
2981	Inlay Repair Necessitated by Restorative Material Failure	111.31
2982	Onlay Repair Necessitated by Restorative Material Failure	111.31
2983	Veneer Repair Necessitated by Restorative Material Failure	111.31
2990	Resin Infiltration of Incipient Smooth Surface Lesions	39.75
5110	Complete Denture, Maxillary	849.78
5120	Complete Denture, Mandibular	849.78
5130	Immediate Denture, Maxillary	926.54
5140	Immediate Denture, Mandibular	926.54
5211	Maxillary Partial Denture, Resin Base	717.20
5212	Mandibular Partial Denture, Resin Base	833.50
5213	Maxillary Partial Denture, Cast Metal Framework with Resin Denture Bases	938.95
5214	Mandibular Partial Denture, Cast Metal Framework with Resin Denture Bases	938.95
5221	Immediate Maxillary Partial Denture Resin Base	856.74
5222	Immediate Mandibular Partial Denture Resin Base	995.14
5223	Immediate Maxillary Partial Denture Cast Metal Framework	1120.81
5224	Immediate Mandibular Partial Denture Cast Metal Framework	1120.81
5225	Maxillary Partial Denture: Flexible Base (including any clasps rests and teeth)	717.20
5226	Mandibular Partial Denture: Flexible Base (including any clasps rests and teeth)	833.50
5281	Removable Unilateral Partial Denture, One Piece Cast Metal	547.40
5670	Replace All Teeth and Acrylic on Cast Metal Framework (maxillary)	341.15
5671	Replace All Teeth and Acrylic on Cast Metal Framework (mandibular)	341.15
6058	Abutment Supported Porcelain/Ceramic Crown	817.22
6059	Abutment Supported Porcelain to Metal Crown High Noble Metal	806.36
6060	Abutment Supported Porcelain to Metal Crown Predominantly Base Metal	762.17
6061	Abutment Supported Porcelain to Metal Crown Noble Metal	777.68

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

ADA CODE	Major Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
6240	Pontic: Porcelain fused to High Noble Metal	576.45
6241	Pontic: Porcelain fused to Base Metal	532.39
6242	Pontic: Porcelain fused to Noble Metal	561.77
6245	Pontic: Porcelain/Ceramic	594.81
6250	Pontic: Resin with High Noble Metal	569.11
6251	Pontic: Resin with Base Metal	525.05
6252	Pontic: Resin with Noble Metal	541.94
6545	Retainer: Cast Metal Resin Bonded Fix Prosthesis	225.75
6548	Retainer: Porcelain/Ceramic for Resin Bonded Fixed Prosthesis	248.32
6549	Resin Retainer – for Resin Bonded Fixed Prosthesis	171.42
6600	Retainer Inlay: Porcelain/Ceramic, 2 Surfaces	448.08
6601	Retainer Inlay: Porcelain/Ceramic, 3 or more Surfaces	469.97
6602	Retainer Inlay: Cast High Noble Metal, 2 Surfaces	478.86
6603	Retainer Inlay: Cast High Noble Metal, 3 or more Surfaces	526.75
6604	Retainer Inlay: Cast Predominantly Base Metal, 2 Surfaces	469.28
6605	Retainer Inlay: Cast Predominantly Base Metal, 3 or more Surfaces	497.33
6606	Retainer Inlay: Cast Noble Metal, 2 Surfaces	461.76
6607	Retainer Inlay: Cast Noble Metal, 3 or more Surfaces	512.38
6608	Retainer Onlay: Porcelain/Ceramic, 2 Surfaces	487.07
6609	Retainer Onlay: Porcelain/Ceramic, 3 or more Surfaces	508.28
6610	Retainer Onlay: Cast High Noble Metal, 2 Surfaces	516.48
6611	Retainer Onlay: Cast High Noble Metal, 3 or more Surfaces	565.05
6612	Retainer Onlay: Cast Predominantly Base Metal, 2 Surfaces	513.75
6613	Retainer Onlay: Cast Predominantly Base Metal, 3 or more Surfaces	537.01
6614	Retainer Onlay: Cast Noble Metal, 2 Surfaces	502.80
6615	Retainer Onlay: Cast Noble Metal, 3 or more Surfaces	522.64
6624	Retainer Inlay: Titanium	478.86
6634	Retainer Onlay: Titanium	502.80
6710	Retainer Crown: Indirect Resin-Based Composite	513.06
6720	Retainer Crown: Resin with High Noble Metal	598.57
6721	Retainer Crown: Resin with Predominantly Base Metal Denture	567.79
6722	Retainer Crown: Resin with Noble Metal	578.05
6740	Retainer Crown: Porcelain/Ceramic	629.36
6750	Retainer Crown: Porcelain fused to High Noble Metal Denture	612.94
6751	Retainer Crown: Porcelain fused Predominantly Base Metal	571.90
6752	Retainer Crown: Porcelain fused to Noble Metal	585.58
6780	Retainer Crown: ¾ Cast High Noble Metal	578.05
6781	Retainer Crown: ¾ Cast Predominantly Base Metal	578.05
6782	Retainer Crown: ¾ Cast Noble Metal Denture	537.01
6783	Retainer Crown: ¾ Porcelain/Ceramic Denture	595.15
6790	Retainer Crown: Full Cast High Noble Metal Denture	591.73
6791	Retainer Crown: Full Cast Predominantly Base Metal Denture	560.95
6792	Retainer Crown: Full Cast Noble Metal Denture	581.47
6794	Retainer Crown: Titanium	581.47
6985	Pediatric Partial Denture, Fixed	305.37
9971	Odontoplasty, 1 to 2 Teeth (includes removal of enamel projections)	60.02

Orthodontia Care:

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

ADA CODE	Orthodontia Care TYPE OF SERVICE	MAXIMUM ALLOWABLE AMOUNT
	Payable at 50%, after Deductible	
0470	Diagnostic Casts	127.21
1510	Space Maintainer: Fixed Unilateral	361.00
1515	Space Maintainer: Fixed Bilateral	505.40
1520	Space Maintainer: Removable Unilateral	397.10
1525	Space Maintainer: Removable Bilateral	613.70
1550	Recementation Space Maintainer	77.98
1555	Removal of Fixed Space Maintainer	75.09
8010 – 8090	Initial Insertion of Appliances	1000.00
8210	Removable Appliance Therapy	200.00
8220	Fixed Appliance Therapy	200.00
8660	Pre-Orthodontic Treatment Visit	61.84
8670	Periodic Orthodontic Treatment Visit	300.00
8680	Orthodontic Retention: Removal of Appliance, Placement of Retainer	654.40
8690	Ortho Treat (alt bill to contract fee)	309.21
8691	Repair Orthodontic Appliance	161.91
8889	Ortho Diagnostic Records, Study Model	100.00