compbenefits

CompBenefits Insurance Company

Schedule B

PLAN DESIGN SUMMARY

- **$50 CALENDAR YEAR DEDUCTIBLE (3 PER FAMILY)**
- **DEDUCTIBLE WAIVED FOR TYPE I SERVICES**
- **$1000 CALENDAR YEAR ANNUAL MAXIMUM**
- **NO WAITING PERIODS ON TYPE I, II, & III**

TYPE I - PREVENTIVE DENTAL SERVICES

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D0120	Periodic oral examination*	$11.70
D0140	Limited oral evaluation - (problem focused)*	15.30
D0150	Comprehensive oral evaluation - new or established patient*	15.30
D0180	Comprehensive periodontal evaluation - new or established patient*	15.30
	*(Covered twice per 12 consecutive months)	
D0210	Intraoral - complete series, inc. bitewings (Covered once per 3 years)	30.60
D0220	Intraoral - periapical - first film	6.30
D0230	Intraoral - periapical - each additional film	6.30
D0240	Intraoral - occlusal film	8.10
D0250	Extraoral - first film	10.80
D0260	Extraoral - each additional	9.00
D0270	Bitewings - single film (Covered twice per 12 consecutive months)	9.90
D0272	Bitewings - two films (Covered twice per 12 consecutive months)	12.60
D0274	Bitewings - four films (Covered twice per 12 consecutive months)	16.20
D0290	Posterior - anterior or lateral skull and facial bone survey film	21.60
D0330	Panoramic film (Covered once per 3 year period)	23.40
D0415	Bacteriologic studies for determination of pathologic agents	18.00
D1110	Prophylaxis - adult (Covered twice per 12 consecutive months)	18.90
D1120	Prophylaxis - child (Covered twice per 12 consecutive months)	18.00
D1201	Topical application of fluoride (prophylaxis included) - child (Covered twice per 12 consecutive months for a dependent child under 16)	21.60
D1203	Topical application of fluoride (prophylaxis not included) - child (Covered twice per 12 consecutive months for a dependent child under 16)	15.30
D1351	Sealant - per tooth (Covered once per 12 consecutive months for a dependent child under age 13)	6.30
D1510	Space maintainer - fixed - unilateral	80.10
D1515	Space maintainer - fixed - bilateral	108.00
D1520	Space maintainer - removable - unilateral	100.80
D1525	Space maintainer - removable - bilateral	109.80
D1550	Recementation of space maintainer	13.50
D7285	Biopsy of oral tissue - hard	45.00
D7286	Biopsy of oral tissue - soft	30.60
D9110	Palliative treatment .(Covered as seperate procedure if no other service, except x-rays, is rendered during the visit)	14.40

TYPE II - BASIC DENTAL SERVICES

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D2140	Amalgam - one surface, primary or permanent*	11.70
D2150	Amalgam - two surfaces, primary or permanent*	18.00
D2160	Amalgam - three surfaces, primary or permanent*	22.50
D2161	Amalgam - four or more surfaces, primary or permanent*	28.80
	*(Multiple restorations on one surface will be covered as a single filling)	
D2330	Resin-based composite- one surface, anterior**	15.30
D2331	Resin-based composite - two surfaces, anterior**	22.50
D2332	Resin-based composite - three surfaces, anterior**	30.60
D2335	Resin-based composite - four or more surfaces or involving incisal angle**	28.80
D2391	Resin-based composite - one surface, posterior**	11.70
D2392	Resin-based composite - two surfaces, posterior**	18.80
D2393	Resin-based composite - three surfaces, posterior**	22.50
D2394	Resin-based composite - four or more surfaces, posterior**	22.50
	**(Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be deemed single surface restorations.)	
D2910	Recement inlay	11.70
D2920	Recement crown	11.70
D2940	Sedative filling (Covered as seperate procedure if no other service, except x-rays, rendered during the visit)	12.60
D2950	Core buildup, including any pins	36.00
D2951	Pin retention - per tooth - in addition to restoration	17.10
D3220	Therapeutic pulpotomy, excluding final restoration	20.70
D3310	Root canal therapy - anterior, excluding final restoration	162.00
D3320	Root canal therapy - bicuspid, excluding final restoration	198.00
D3330	Root canal therapy - molar, excluding final restoration	243.00
D3351	Apexification/recalcification - initial visit	45.90

TYPE II - BASIC DENTAL SERVICES (CONT.)

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D3352	Apexification/recalcification - interim medication	45.90
D3353	Apexification/recalcification - final visit	45.90
D3410	Apicoectomy/periradicular surgery - anterior	71.10
D3421	Apicoectomy/periradicular surgery - bicuspid	71.10
D3425	Apicoectomy/periradicular surgery - molar	71.10
D3430	Retrograde filling - per tooth	26.10
D3450	Root amputation - per root	38.70
D3920	Hemisection (including root removal), not including root canal therapy	38.70
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth, per quadrant***	51.30
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant***	13.50
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth, per quadrant***	57.60
D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant***	57.60
	***(Only one of these procedures is covered per area of the month.)	
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth, per quadrant	95.40
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	95.40
D4270	Pedicle soft tissue graft procedure	57.60
D4271	Free soft tissue graft procedure (including donor site surgery)	63.90
D4320	Provisional splinting - intracoronal	18.00
D4321	Provisional splinting - extracoronal	18.00
D4341	Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth, per quandrant****	14.40
D4342	Periodontal scaling and root planing, one to three teeth, per quadrant****	14.40
D4355	Full mouth debridement to enable comprehensive eval. and diagnosis****	30.60
D4910	Periodontal maintenance****	19.80
	****(Covered twice per area of the mouth per 12 consecutive months)	
D5510	Repair broken complete denture base*****	26.10
D5520	Replace missing or broken teeth - complete denture*****	26.10
D5610	Repair resin denture base*****	26.10
D5620	Repair cast framework*****	26.10
D5630	Repair or replace broken clasp*****	30.60
D5640	Replace broken teeth - per tooth*****	18.90
D5650	Add tooth to existing partial denture*****	36.00
D5660	Add clasp to existing partial denture*****	38.70
D5710	Rebase complete maxillary denture*****	76.50
D5711	Rebase complete mandibular denture*****	76.50
D5720	Rebase maxillary partial denture*****	76.50
D5721	Rebase mandibular partial denture*****	76.50
	*****(Covered only if repairs/adjustments more than 1 year after the initial insertion)	
D6930	Recement fixed partial denture	16.20
D7111	Coronal remnants, deciduous tooth	14.40
D7140	Extraction, erupted tooth or exposed root (elev. and/or forceps removal)	14.40
D7210	Surgical removal of erupted tooth	26.10
D7220	Removal of impacted tooth - soft tissue	36.00
D7230	Removal of impacted tooth - partially bony	45.90
D7240	Removal of impacted tooth - completely bony	61.20
D7250	Surgical removal of residual tooth roots	28.80
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	47.70
D7272	Tooth transplantation	51.30
D7310	Alveoloplasty in conjunction with extractions - per quadrant	21.60
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21.60
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	25.20
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	25.20
D7340	Vestibuloplasty - ridge extension (second epithelialization)	38.70
D7350	Vestibuloplasty - ridge extension (incl. tissue procedures)	76.50
D7510	Incision and drainage of abscess - intraoral soft tissue	22.50
D7520	Incision and drainage of abscess - extraoral soft tissue	34.20
D7960	Frenulectomy - separate procedure	33.30
D7970	Excision of hyperplastic tissue - per arch	38.70

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TYPE II - BASIC DENTAL SERVICES (CONT.)

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D9220	Deep sedation/general anesthesia - first 30 minutes^	30.60
	^(Covered as a separate procedure only when required for covered complex oral surgical procedures as determined by the company)	
D9610	Therapeutic drug injection	11.70
D9951	Occlusal adjustment - limited^^	14.40
D9952	Occlusal adjustment - Complete^^	36.90
	^^Covered only when performed with periodontal surgery or nonsurgical TMJ dysfunction treatment)	

TYPE III - MAJOR DENTAL SERVICES

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D0470	Diagnostic casts	15.30
D2510	Inlay - metallic - one surface	57.60
D2520	Inlay - metallic - two surfaces	79.20
D2530	Inlay - metallic - three or more surfaces	85.50
D2610	Inlay - porcelain/ceramic - one surface	26.10
D2620	Inlay - porcelain/ceramic - two surfaces	52.20
D2630	Inlay - porcelain/ceramic - three or more surfaces	78.30
D2710	Crown resin (laboratory) (Single restoration only)	51.30
D2720	Crown - resin high noble metal (Single restoration only)	98.10
D2721	Crown - resin predominantly base metal (Single restoration only)	85.50
D2722	Crown - resin with noble metal (Single restoration only)	89.10
D2740	Crown - porcelain/ceramic substrate (Single restoration only)	95.40
D2750	Crown - porcelain fused to high noble metal (Single restoration only)	180.00
D2751	Crown - porcelain fused to predominantly base metal (Single restoration only)	91.80
D2752	Crown - porcelain fused to noble metal (Single restoration only)	95.40
D2790	Crown - full cast high noble metal (Single restoration only)	175.50
D2791	Crown - full cast predominantly base metal (Single restoration only)	82.80
D2792	Crown - full cast noble metal (Single restoration only)	89.10
D2930	Prefabricated stainless steel crown - primary tooth (Single restoration only)	21.60
D2931	Prefabricated stainless steel crown - permanent (Single restoration only)	21.60
D2952	Cast post and core in addition to crown (Single restoration only)	36.00
D2954	Prefabricated post and core in addition to crown (Single restoration only)	26.10
D5110	Complete upper denture	129.60
D5120	Complete lower denture	129.60
D5130	Immediate upper denture	135.90
D5140	Immediate lower denture	135.90
D5211	Upper partial denture - resin base	79.20
D5212	Lower partial denture - resin base	79.20
D5213	Upper partial denture - cast metal base with resin saddles	145.80
D5214	Lower partial denture - cast metal base with resin saddles	134.10
D5281	Removable unilateral partial denture - one piece cast metal	28.80
D5410	Adjust complete denture - upper*	8.10

TYPE III - MAJOR DENTAL SERVICES (CONT.)

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D5411	Adjust complete denture - lower*	8.10
D5421	Adjust partial denture - upper*	8.10
D5422	Adjust partial denture - lower*	8.10
	*(Covered only once per 12 consecutive months and only if done more than one year after the initial insertion of the denture)	
D5730	Reline complete upper denture (chairside)**	32.40
D5731	Reline complete lower denture (chairside)**	32.40
D5740	Reline upper partial denture (chairside)**	26.10
D5741	Reline lower partial denture (chairside)**	26.10
D5750	Reline complete upper denture (laboratory)**	47.70
D5751	Reline complete lower denture (laboratory)**	47.70
D5760	Reline upper partial denture (laboratory)**	41.40
D5761	Reline lower partial denture (laboratory)**	41.40
	**(Covered only if relining is done more than 1 year after the initial insertion and then not more than once per 2 year period)	
D6210	Pontic - cast high noble metal	175.50
D6211	Pontic - cast predominantly base metal	82.80
D6212	Pontic - cast noble metal	89.10
D6240	Pontic - porcelain fused to high noble metal	180.00
D6241	Pontic - porcelain fused to predominately base metal	91.80
D6242	Pontic - porcelain fused to noble metal	95.40
D6250	Pontic - resin with high noble metal	98.10
D6251	Pontic - resin with predominately base metal	85.50
D6252	Pontic - resin with noble metal	89.10
D6602	Inlay - cast high noble metal, two surfaces***	79.20
D6603	Inlay - cast high noble metal, three or more surfaces***	85.50
D6604	Inlay - cast predominantly base metal two surfaces***	79.20
D6605	Inlay - cast predominantly base metal three or more surfaces***	85.50
D6606	Inlay - cast noble metal, two surfaces***	79.20
D6607	Inlay - cast noble metal, three or more surfaces***	85.50
D6720	Crown - resin with high noble metal***	98.10
D6721	Crown - resin with predominately base metal***	85.50
D6722	Crown - resin with noble metal***	89.10
D6750	Crown - porcelain fused to high noble metal***	180.00
D6751	Crown - porcelain fused to predominately base metal***	91.80
D6752	Crown - porcelain fused to noble metal***	95.40
D6780	Crown - 3/4 cast high noble metal***	91.80
D6790	Crown - full cast high noble metal***	175.50
D6791	Crown - full cast predominately base metal***	85.50
D6792	Crown - full cast noble metal***	89.10
	***(Bridge retainers - initial placement of replacement.)	

PROCEDURES NOT LISTED ON THE SCHEDULE MAY BE CHARGED AT THE DENTIST'S USUAL AND CUSTOMARY FEE.

MAJOR RESTORATIVE LIMITATIONS

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. A denture, partial denture, or fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy, however, this provision will not apply if the Policy replaces a prior policy You had with another insurer and You are covered by this Policy on its Effective Date without a break in coverage provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
2. The replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
3. The replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
4. The replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
5. The replacement of teeth up to the normal complement of 32.

EXCLUSIONS

Benefits will not be paid for:

1. Procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
2. Any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by CompBenefits;
3. Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
4. Appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;
5. Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
6. Pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
7. Charges for travel time; transportation costs; or professional advice given on the phone;
8. Procedures performed by a Dentist who is a member of Your immediate family;
9. Any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;
10. Charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any mem¬ber of Your family;
11. Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
12. Charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of $100 (US dollars) per year;
13. The care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
14. Treatment for cosmetic purposes - facings on crowns or bridge units on molar teeth will always be considered cosmetic;
15. Any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;
16. Procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
17. An injury that arises out of or in the course of a job or employment for pay or profit for which benefits are available under any workers' compensation act or similar law; or
18. Charges to the extent that they are more than the Reimbursement Rate. If the amount of the Reimbursement Rate for a service cannot be determined due to the unusual nature of the service, CompBenefits will determine the amount. CompBenefits will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors;
19. orthodontic plan benefits for persons 19 years of age or older.

PREDETERMINATION

If Covered Dental Expenses for a procedure are expected to be more than $200 it is recommended that you send a Dental Treatment Plan in prior to beginning treatment, send preauthorization to CompBenefits, P.O. Box 8236 Chicago, IL 60680–8236. You and/or your dentist will be notified of the benefits payable based upon the Dental Treatment Plan.

This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures is found in the Schedule of Benefits and Certificate of Group Dental Insurance.

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