CompBenefits Insurance Company

Elite Schedule 75

Plan Design Summary

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

TYPE I - PREVENTIVE DENTAL SERVICES

ADA CODES	PROCEDURE	MAXIMUM REIMBURSEMENT
D0120	PERIODIC ORAL EVALUATION (covered twice per 12 consecutive mos)	$21
D0210	INTRAORAL-COMPLETE SERIES INCLUDING BITEWINGS (covered once per 3 year period)	50
D0220	INTRAORAL-PERIAPICAL-FIRST FILM	10
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	8
D0240	INTRAORAL-OCCLUSAL FILM	11
D0250	EXTRAORAL-FIRST FILM	10
D0260	EXTRAORAL-EACH ADDITIONAL FILM	13
D0270	BITEWINGS-SINGLE FILM (covered twice per 12 consecutive months)	12
D0272	BITEWINGS-TWO FILMS (covered twice per 12 consecutive months)	16
D0274	BITEWINGS-FOUR FILMS (covered twice per 12 consecutive months)	22
D0290	POSTERIOR/ANTERIOR/LATERAL SKULL/FACIAL BONE SURVEY FILM	43
D0330	PANORAMIC FILM (covered once per 3 year period)	44
D0415	BACTERIOLOGIC STUDIES (pathologic agents)	13
D1110	PROPHYLAXIS-ADULT (covered twice per 12 consecutive months)	32
D1120	PROPHYLAXIS-CHILD (covered twice per 12 consecutive months)	26
D1201	TOPICAL FLUORIDE application-CHILD (including prophylaxis) (covered twice per 12 consecutive months, but only for a dependent child under age 16)	38
D1203	TOPICAL FLUORIDE application-CHILD (excluding prophylaxis) (covered twice per 12 consecutive months, but only for a dependent child under age 16)	13
D1351	SEALANT-PER TOOTH (covered once per 12 consecutive months for dependent child under age 13)	16
D1510	SPACE MAINTAINER-FIXED-UNILATERAL	131
D1515	SPACE MAINTAINER-FIXED-BILATERAL	231
D1520	SPACE MAINTAINER-REMOVABLE-UNILATERAL	170
D1525	SPACE MAINTAINER-REMOVABLE-BILATERAL	200
D1550	RECEMENTATION OF SPACE MAINTAINER	32
D7285	BIOPSY OF ORAL TISSUE-HARD	105
D7286	BIOPSY OF ORAL TISSUE-SOFT	105
D9110	PALLIATIVE TREATMENT (covered as a separate procedure only if no other service, except x-rays is rendered during the visit)	32

TYPE II - BASIC DENTAL SERVICES

D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT*	34
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT*	43
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT*	54
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT* *(multiple restorations on one surface will be covered as a single filling)	71
D2330	RESIN-ONE SURFACE, ANTERIOR**	37
D2331	RESIN-TWO SURFACES, ANTERIOR**	47
D2332	RESIN-THREE SURFACES, ANTERIOR**	58
D2335	RESIN-FOUR + SURFACES OR INVOLVING INCISAL ANGLE**	63
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR**	42
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR**	63
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR**	76
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR** **(Mesial-lingual, distal-lingual, mesial-buccal, and distal-bucca restorations on anterior teeth will be deemed single surface restorations)	80
D2910	RECEMENT INLAY	25
D2920	RECEMENT CROWN	29
D2940	SEDATIVE FILLING	34
D2950	CORE BUILD-UP, INCLUDING ANY PINS	84
D2951	PIN RETENTION/PER TOOTH, IN ADDITION TO RESTORATION	19
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)	55
D3310	ROOT CANAL-ANTERIOR	210
D3320	ROOT CANAL-BICUSPID	242
D3330	ROOT CANAL-MOLAR	273
D3351	APEXIFICATION/RECALCIFICATION-INITIAL VISIT	84
D3352	APEXIFICATION/RECALCIFICATION INTERIM MEDICATION	84
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT	84
D3410	APICOECTOMY/PERIRADICULAR SURGERY- ANTERIOR	248

TYPE II - BASIC DENTAL SERVICES (CON'T.)

ADA CODES	PROCEDURE	MAXIMUM REIMBURESEMENT
D3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID	$210
D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR	210
D3426	APICOECTOMY/PERIRADICULAR SURGERY (each additional root)	121
D3430	RETROGRADE FILLING-PER ROOT	67
D3450	ROOT AMPUTATION-PER ROOT	168
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL)	155
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS OR BOUNDED TEETH, PER QUAD***	105
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE TEETH, PER QUADRANT***	63
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH, PER QUADRANT***	158
D4241	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT*** ***(Limit 1 per 1 year period)	95
D4260	OSSEOUS SURGERY - (INCLUDING FLAP ENTRY AND CLOSURE) FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH, PER QUADRANT	315
D4261	OSSEOUS SURGERY - (INCLUDING FLAP ENTRY AND CLOSURE) ONE TO THREE TEETH, PER QUADRANT	189
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	311
D4271	FREE SOFT TISSUE GRAFT PROCEDURE	302
D4320	PROVISIONAL SPLINTING-INTRACORONAL	118
D4321	PROVISIONAL SPLINTING-EXTRACORONAL	84
D4341	PERIODONTAL SCALING AND ROOT PLANING, FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH, PER QUADRANT (Limit 2 per 1 year period)	74
D4342	PERIODONTAL SCALING/ ROOT PLANING, ONE TO THREE TEETH, PER QUADRANT (Limit 2 per 1 year period)	44
D4910	PERIODONTAL MAINTENANCE (covered twice per area of the mouth per 12 consecutive months)	42
D5510	REPAIR BROKEN COMPLETE DENTURE BASE ****	46
D5520	REPLACE MISSING/BROKEN TEETH-COMPLETE DENTURE****	42
D5610	REPAIR RESIN SADDLE OR BASE****	55
D5620	REPAIR CAST FRAMEWORK****	46
D5630	REPAIR OR REPLACE BROKEN CLASP****	71
D5640	REPLACE BROKEN TEETH-PER TOOTH****	46
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE****	67
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE****	75
D5710	REBASE COMPLETE UPPER DENTURE****	84
D5711	REBASE COMPLETE LOWER DENTURE****	84
D5720	REBASE UPPER PARTIAL DENTURE****	84
D5721	REBASE LOWER PARTIAL DENTURE**** ****(covered only if repairs/adjustments are done more than 1 year after the initial insertion)	84
D6930	RECEMENT BRIDGE	42
D7111	CORONAL REMNANTS - DECIDUOUS TOOTH	38
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (elevation and/or forceps removal)	38
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	76
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	109
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	153
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	164
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	63
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH	86
D7272	TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER)	84
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS-PER QUADRANT	76
D7320	ALVEOLOPLASTY NOT IN CONJUNC WITH EXTRACTIONS-PER QUADRANT	96
D7340	VESTIBULOPLASTY-RIDGE EXTEN(SECNDRY EPITHELIZTN)	151
D7350	VESTIBULOPLASTY-RIDGE EXTEN (W/SOFT TISS GFT)	168
D7510	I & D ABSCESS INTRAORAL-SOFT TISSUE	50
D7520	I & D ABSC-EXTRAORAL SOFT TISSUE	76
D7960	FRENULECTOMY (FRENECTOMY/FRENOTOMY) SEPARATE PROCEDURE	147
D7970	EXCISION OF HYPERPLASTIC TISSUE/ PER ARCH	92
D9220	DEEP SEDATION/GENERAL ANETHESIA - FIRST 30 MINUTES	116
D9221	DEEP SEDATION/GENERAL ANESTHESIA-EACH ADDL 15 MINUTES	79

TYPE II- MAJOR DENTAL SERVICES (CON'T.)

ADA CODES	PROCEDURE	MAXIMUM REIMBURSEMENT
D9610	THERAPEUTIC DRUG INJECTION	$17
D9951	OCCLUSION ADJUSTMENT-LIMITED	29
D9952	OCCLUSION ADJUSTMENT-COMPLETE	126

TYPE III - MAJOR DENTAL SERVICES

D0470	DIAGNOSTIC CASTS	20
D2510	INLAY-METALLIC-ONE SURFACE	147
D2520	INLAY-METALLIC-TWO SURFACES	171
D2530	INLAY-METALLIC-THREE OR MORE SURFACES	204
D2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	142
D2620	INLAY-PORCELAIN/CERAMIC-TWO SURFACES	158
D2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES	173
D2710	CROWN-RESIN (INDIRECT)	50
D2720	CROWN-RESIN W/HIGH NOBLE METAL	105
D2721	CROWN-RESIN W/PREDOMINANTLY BASE METAL	95
D2722	CROWN-RESIN W/NOBLE METAL	100
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	250
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	226
D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	210
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	224
D2790	CROWN-FULL CAST HIGH NOBLE METAL	236
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	213
D2792	CROWN-FULL CAST NOBLE METAL	224
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	50
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	56
D2952	CAST POST AND CORE IN ADDITION TO CROWN	74
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	71
D2970	TEMPORARY CROWN (FRACTURED TOOTH)	50
D5110	COMPLETE DENTURE-MAXILLARY	261
D5120	COMPLETE DENTURE-MANDIBULAR	259
D5130	IMMEDIATE DENTURE-MAXILLARY	289
D5140	IMMEDIATE DENTURE-MANDIBULAR	277
D5211	MAXILLARY PART DENTURE-RESIN BASE (CLASP/RESTS)	313
D5212	MANDIBULAR PART DENTURE-RESIN BASE (CLASP/RESTS)	315
D5213	MAXILLARY PART DENTURE-METAL FRAME W/RESIN BASE	236
D5214	MANDIBULAR PART DENTURE-METAL FRAME W/RESIN BASE	236
D5281	REMOV UNILAT PART DENTURE-1 PIECE METAL (W/TEETH)	126
D5410	ADJUST COMPLETE DENTURE-MAXILLARY	15

TYPE III - MAJOR DENTAL SERVICES (CON'T.)

ADA CODES	PROCEDURE	MAXIMUM REIMBURSEMENT
D5411	ADJUST COMPLETE DENTURE-MANDIBULAR	$16
D5421	ADJUST PARTIAL DENTURE-MAXILLARY	14
D5422	ADJUST PARTIAL DENTURE-MANDIBULAR	15
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	58
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	66
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	63
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	63
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	81
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	82
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	84
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	79
D6210	PONTIC-CAST HIGH NOBLE METAL	236
D6211	PONTIC-CAST PREDOMINANTLY BASE METAL	197
D6212	PONTIC-CAST NOBLE METAL	203
D6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	224
D6241	PONTIC-PORCELAIN FUSED TO PREDOM. BASE METAL	210
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	224
D6250	PONTIC-RESIN W/HIGH NOBLE METAL	224
D6251	PONTIC-RESIN W/predominantly base metal	213
D6252	PONTIC-RESIN W/NOBLE METAL	218
D6602	INLAY - CAST HIGH NOBLE METAL, TWO SURFACES	184
D6603	INLAY - CAST HIGH NOBLE METAL, THREE OR MORE SURFACES	210
D6604	INLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES	184
D6605	INLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES	210
D6606	INLAY - CAST NOBLE METAL TWO SURFACES	184
D6607	INLAY - CAST NOBLE METAL THREE OR MORE SURFACE	210
D6720	CROWN-RESIN W/HIGH NOBLE METAL	184
D6721	CROWN-RESIN W/PREDOMINANTLY BASE METAL	171
D6722	CROWN-RESIN W/NOBLE METAL	184
D6750	CROWN-RETAINER-PORCELAIN FUSED HIGH NOBLE METAL	224
D6751	CROWN-RETAINER-PORCELAIN FUSED PRED. BASE METAL	210
D6752	CROWN-RETAINER-PORCELAIN FUSED TO NOBLE METAL	224
D6780	CROWN-RETAINER 3/4 CAST HIGH NOBLE METAL	211
D6790	CROWN-RETAINER-FULL CAST HIGH NOBLE METAL	239
D6791	CROWN-RETAINER-FULL CAST PREDOM. BASE METAL	208
D6792	CROWN-RETAINER-FULL CAST NOBLE METAL	218

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 within12 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 uniformprofessional 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 member 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 for 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 Insurance Company will determine the amount. CompBenefits Insurance Company will take into account: (a) the complexity involved; b) the degree of professional skill required; and (c) other pertinent factors; or

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.

CompBenefits Family of Companies

CompBenefits • CompBenefits Company • CompBenefits Insurance Company • CompBenefits of Alabama, Inc.
CompBenefits Dental, Inc. • American Dental Plan of North Carolina, Inc.
American Dental Providers of Arkansas, Inc • National Dental Plans, Inc.
American Dental Plan of Georgia, Inc. • Texas Dental Plans, Inc.• Ultimate Optical, Inc.
VisionCare Plan • Primary Plus