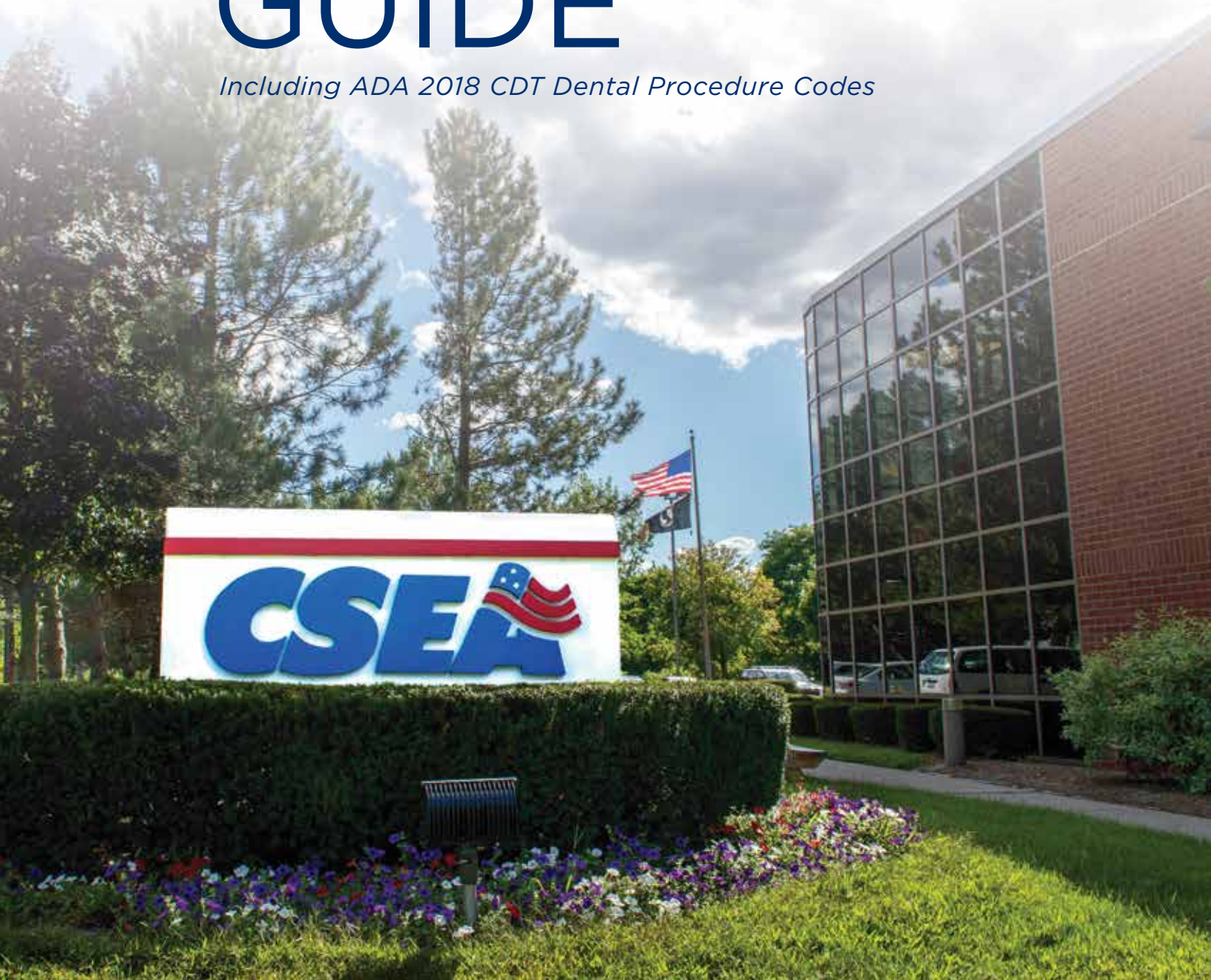




CSEA EMPLOYEE BENEFIT FUND

DENTAL PROVIDER GUIDE

Including ADA 2018 CDT Dental Procedure Codes



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Website: www.cseaebf.com

Phone Number: 800-323-2732

Business Hours: Monday through Friday, 7:30 a.m. - 5 p.m.

Change Healthcare (formerly WebMD/Emdeon), Tesia and Dentalxchange: Payer Number, CX 054

Claim Address: CSEA Employee Benefit Fund, PO Box 489, Latham, NY 12110-0489

Address: CSEA Employee Benefit Fund, 1 Lear Jet Lane, Suite 1, Latham, NY 12110-2395

For the most current plan information, please visit us online at www.cseaebf.com or contact our dental department at 800-323-2732. Please be advised that the contents of this guide are subject to change. Although every effort has gone into providing accurate information, we are not responsible for typographical errors.



Dear Provider:

On behalf of the CSEA Employee Benefit Fund (EBF) Board of Trustees, I am pleased to provide you with a revised copy of the EBF's Dental Provider Guide. This publication was compiled to provide you with the most accurate and up to date information about the EBF.

We are proud of the benefits that the EBF is able to make available to our hardworking CSEA members and their families, as well as the high professional standards under which the EBF operates. The EBF is dedicated to serving our members and treating our panel of providers as full partners in that mission. This Dental Provider Guide offers a comprehensive introduction to EBF benefits that should serve as an important reference source.

Please note that this edition of the Guide includes a new **ADA CDT 2018 Summary** of covered procedure codes and associated fees for each of the EBF's nine dental plans.

Thank you for your interest and support for our members. We truly value our partnership with you.

Sincerely,

A handwritten signature in black ink that reads "Danny Donohue". The signature is written in a cursive style with a large, looping initial "D".

Danny Donohue, *Chairman*

A handwritten signature in black ink that reads "Bill Howard". The signature is written in a cursive style with a large, looping initial "B".

Bill Howard, *Director*

After an employee is fully enrolled in one of the CSEA EBF dental plans, an ID card with a randomly generated nine digit number is sent to the member. The same number is used for all eligible dependents in the employee's family.

The EBF ID number must be used for claim submission and inquiries. Please visit our website www.cseabf.com and visit the "Provider Portal" to look up a member's EBF ID Number.



VERIFY ELIGIBILITY

When you call with a question our customer service staff needs the EBF ID number to assist you as efficiently as possible. To verify patient eligibility please call 800-323-2732 and speak with our dental department. Our customer service representatives will be able to assist you with eligibility questions and plan information.

- » Eligibility changes frequently. Claims are processed based on the eligibility status for the date of service
- » Possession of a benefit card is not proof of eligibility

STUDENT STATUS

Unmarried dependent children/legal wards are covered until age 19. Upon turning age 19 proof of student status must be on file at the Fund annually to extend coverage until age 25.

Dependents who are incapable of self-support, regardless of age, by reason of mental or physical disability and who became so disabled before reaching age 19 may have coverage extended.

TAX IDENTIFICATION NUMBER (TIN)

DO YOUR TIN AND BUSINESS NAME MATCH?

The Internal Revenue Service requires one business name or individual name per TIN. You should report and receive all earnings under the TIN / business name issued by the IRS. Separate doctors within the business should submit under the business name. DBA (Doing Business As) names should not be used for claim submissions.

Please contact the Fund to verify your TIN / business name if you have not updated with us recently.

WHEN TO NOTIFY US OF AN UPDATE

Please notify us immediately of any changes including the following:

- » Adding a new location to your existing practice
- » Change of address
- » Close a location
- » Name change
- » New TIN
- » Addition or termination of providers

WHO DO I CONTACT?

Please call 800-323-2732 and ask for provider relations or email contact@cseabf.org for any questions.

REQUIRED ATTACHMENTS

HELP US, HELP YOU

Save time and money by following these rules for submitting attachments.

RADIOGRAPHS

Radiographs must be current, labeled (with date / name of patient), and should be denoted right and left. You must submit diagnostic quality radiographs for the following services:

- » Fixed bridge work
- » Crowns
- » Inlays / onlays
- » Post-Op Implants

Occasionally, we will need to request radiographs for other services.

According to ADA and HIPAA regulations only duplicates should be sent to us; the originals should be retained for your records.

Please be advised the Fund does not return radiographs.

PERIODONTAL REQUIREMENTS

Periodontal charting and pre-op x-rays are required for gingivectomy, osseous surgery and bone replacement graft (D4263) procedures.

NARRATIVE / COPIES OF TREATMENT RECORDS

Occasionally, we will request a clinical description, narrative or a copy of the patient's treatment record.

PHOTOGRAPHIC IMAGES

If you feel a photographic image will best support your claim and treatment plan, you may include a copy with your claim or predetermination.

PRIMARY EXPLANATION OF BENEFIT FORMS

If the CSEA EBF is the secondary benefit coverage, you must submit a copy of the primary explanation of benefit form with the claim.

Primary insurance information is not required for predeterminations.

HOW TO SUBMIT ATTACHMENTS

SUBMISSION METHODS

We accept the following submission methods:

NATIONAL ELECTRONIC ATTACHMENT (WWW.NEAFast.COM)

Attachments such as radiographs, primary Explanation of Benefit statements, narratives and periodontal charting can be sent to us via NEA.

MAILED ATTACHMENTS

Do not send radiographs unless you are submitting for the procedures listed in the above section or have received a special request from our office or consultant. Please be sure to label all attachments.

**Change Healthcare,
Tesia and Dentalxchange
Payer Number:
CX 054**

**Claim Address:
CSEA Employee Benefit Fund
PO Box 489
Latham NY 12110-0489**

ELECTRONIC CLAIMS & PREDETERMINATIONS

Claims and predeterminations can be submitted electronically. This is generally the most efficient way to submit claims and results in the fastest turnaround time.

Accurate information is important to ensure proper processing of claims. All claims must include the correct EBF ID number (not the SS#), patient's legal name (spelling is important), date of birth, relationship to member and provider's name, address and provider's current tax identification number. If this information is not correct, the claim may be rejected back to your clearinghouse.

Your electronic claims should be submitted through your clearinghouse to ours which is Change Healthcare, Tesia and Dentalxchange.

Our payer number is CX054

National Electronic Attachment
(www.neafast.com)

Attachments such as radiographs, primary Explanation of Benefit statements, narratives and periodontal charting can be sent to us via NEA.

PAPER CLAIMS & PREDETERMINATIONS

A universal American Dental Association (ADA) claim form or a CSEA EBF claim form must be used to submit predeterminations or claims for payment. We do not accept receipts or small statements as claim for payment.

On page 31 of this guide, there is a copy of the EBF Claim Form, which you may photocopy. It is also available for download from our website: www.cseaebf.com

Accurate information is important to ensure proper processing of claims. All claims must include the correct EBF ID number (not the SS#), patient's

legal name (spelling is important), date of birth, relationship to member and provider's name, address and provider's current tax identification number.

Submit services using the most current ADA CDT codes.

Submit all claims with the fee(s) your office would normally charge for service(s) rendered.

Always include correct teeth numbers and identify missing teeth when submitting for partial dentures.

Claims should be submitted using white paper, black ink and a font size of 10-12 point. Illegible or handwritten claims will often be rejected by the scanner and can delay the processing of claims.

*Paper Claims and Predeterminations
should be submitted to:*

**CSEA Employee Benefit Fund
PO Box 489
Latham NY 12110-0489**

PROCESSING TIME

Claim processing turnaround times can vary according to the volume of dental claims that we receive. To assist us with making the process as efficient as possible please follow the guidelines delineated within this guide.

TIMELY FILING

No claims will be considered if submitted after a period that exceeds one year from the date the dental services were rendered.

Whenever the estimated cost of a recommended dental treatment exceeds \$500.00, we advise the submission of a predetermination before the work begins.

We accept predeterminations electronically or via paper claim form. To ensure efficient processing, please include radiographs and/or periodontal charting when needed. Please refer to the Attachment Submission Guideline section on page 5 for more information.

PROCESSING

Please allow 4-6 weeks for processing since many of the services that are predetermined must be reviewed by our outside consultants.

BENEFIT DETERMINATION

After processing, the Fund will notify the member and the provider of the benefits payable based upon the treatment plan, rules and limitations of

the applicable dental plan and the patient's dental history.

In determining the amount of benefits payable, consideration will be given to alternate procedures that will accomplish a professionally acceptable result.

If the member and the dentist agree to a more expensive method of treatment than the amount pre-authorized by the Fund, the amount exceeding the predetermination will not be paid by the Fund even if it would otherwise be a covered service.

PATIENT ELIGIBILITY

A predetermination is not a guarantee of benefits. Payment is subject to eligibility at the time of service.

12 MONTH EXPIRATION

Once a predetermination has been processed, it is valid for 12 months.

APPEALS

If you feel that you did not receive full benefits, you may appeal to the Fund. Please call customer service at 1-800-323-2732 and request a dental claim appeal form which can be emailed or mailed to you.

HOW TO FILE

Send a letter to the Fund's Dental Supervisor explaining why you are appealing the benefit that was allowed or disallowed.

Include supporting documentation: Narratives, radiographs, periodontal charting or photographic images.

All appeals must be submitted within 60 days of the determination being appealed.

Please note the appeal process could take up to 4-6 weeks.

The appeal procedure is not designed to cover clerical mistakes on claims which may be corrected by a phone call to the Fund.

The appeal procedure is not meant for services that are not covered by our dental plans or for exemptions to or waivers of required waiting periods.

**CSEA Employee Benefit Fund
Attn: Dental Supervisor
PO Box 489
Latham NY 12110-0489**

AFFORDABLE CARE ACT (ACA)

The CSEA EBF is ACA Compliant.

ELIGIBILITY

A plan member or dependent must be eligible at the time of service. Any service rendered or appliance inserted before the eligibility date or after the termination date under CSEA EBF Plans are not covered.

COORDINATION OF BENEFITS

Since it is not intended that the patient receive greater benefits than the actual expenses covered, the amount of benefits payable under the CSEA EBF Dental Plans will take into account any coverage the employee (or eligible dependent) has under other group plans. In other words, the benefits under the CSEA EBF Dental Plans will be coordinated with the benefits of the other group plans.

An employee may not be covered both as an employee and as a dependent of an employee. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are Fund members, coverage for children may not be claimed under both.

BIRTHDAY RULE

Coordination of benefits regulation states that the primary payer of benefits for dependent children is determined by the parent who has the earlier birth date by month and day, without regard to the year of birth. Other determining factors may apply.

MEMBER OUT-OF-POCKET EXPENSES / ALLOWANCES / SPECIALIST POLICY

Participating Providers have agreed by contract to accept the listed fees as payment in full, whether payments are made by the Fund, the covered employees or their dependents. There should be no out-of-pocket costs to our members for paid covered services.

A provider **either participating or non-participating** will be permitted to charge their customary fees for the implant body and implant abutment procedures and accept the implant allowances (\$1,000 for implants and \$250 for abutments) against such fees. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.

If a covered service is denied a benefit due to a plan restriction, the member is responsible for paying the amount the Fund would have paid. For non-covered services the member is responsible for paying the provider's fees.

Specialists within participating general practices have the right to bill members for the difference between the specialist's customary charge and the allowance which the CSEA Employee Benefit Fund pays under the dental plans. The Specialist must inform the Fund and the member that he/she will not be accepting the plan of allowance as payment in full and must provide proof of specialty status to the Fund.

PROFESSIONAL REVIEW

Crowns, inlays, onlays, bridges, implants, periodontal procedures, and some other specialty procedures will be reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the plan.

The Fund, with the advisement of our dental consultants, will determine benefit coverage. The treatment choices are always between the provider and the patient.

WORKER'S COMPENSATION

Treatment covered by Workers' Compensation or similar law is not covered by the Fund.

"NO-FAULT" AUTOMOBILE INSURANCE

Charges for expenses which are reimbursable through "no-fault" automobile insurance are not covered by the Fund.

PAYMENT UPON COMPLETION

Claim payment is made upon completion of work or insertion of an appliance.

LOST OR STOLEN APPLIANCE

The Fund does not provide coverage for replacement of a lost or stolen prosthetic appliance if lost before the frequency limitation has expired.

LICENSED PRACTITIONERS ONLY

Treatment must be performed by a licensed dentist or dental hygienist acting within the scope of licensure.

AMALGAM AND COMPOSITE RESTORATIONS

Fillings are allowed once per each surface, per tooth, per 12 months, regardless of materials used.

PERIODONTICS AGE LIMITATION 19

Benefits will not be paid for periodontic procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity.

PERIODONTAL SURGERY

Benefits will be paid for only the most comprehensive surgical procedure necessary in each site.

PROSTHODONTIC COVERAGE (5 YEAR RULE)

Our plans allow one prosthodontic replacement per 5 years. A tooth is allowed a prosthodontic replacement, which includes crowns, pontics, inlays, onlays and partial and full dentures, once per five years.

In order to provide a benefit for replacement prosthodontics the Fund must be furnished satisfactory evidence that: the existing crown, bridgework or denture was inserted at least five years prior to its replacement and that the existing crown, bridgework or denture cannot be made serviceable by a dentist.

Examples:

If a tooth has had a crown within 5 years of a pontic, the pontic is subject to the 5 year frequency limitation.

If a full denture is inserted within 5 years of a partial denture, the full denture is subject to the five year frequency limitation.

If a crown replacement is needed within five years of the original crown, the new crown is subject to the five year frequency limitation.

If an implant is needed within 5 years of the original crown, the implant supported crown is subject to the 5 year frequency limitation.

SURGICAL IMPLANTS AND IMPLANT/ABUTMENT SUPPORTED PROSTHODONTICS (10 YEAR RULE)

Implants and implant abutment supported prosthetics including dentures, partial dentures, bridges and crowns will be subject to a 10 year replacement rule.

MINI IMPLANTS Not a covered benefit.

PERMANENT AND INTERIM DENTURE PAYMENTS

A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. The Fund will pay for no other installation within the next five year period. Benefits are payable upon insertion.

DENTURE ADJUSTMENTS

The prosthodontic allowance includes all adjustments and relines for 6 months following the insertion of the appliance. **If the plan** covers adjustments to dentures a benefit will be allowed 6 months after the insertion of the denture and only once per 12 month period.

PRECISION OR ELABORATE ATTACHMENTS OR FEATURES

Precision or other elaborate attachments or features for dentures, bridgework or any other dental appliances are not covered.

VERTICAL DIMENSION CORRECTION

Dentures, crowns, inlays, bridgework or appliances to change or maintain vertical dimension are not covered.

SPLINTING

Any casting placed for stabilization is not covered.

SEALANTS

This benefit is allowed only for permanent premolars and molars, 1 per tooth, per 3 years, only if the occlusal surface has not previously been restored with a composite or amalgam restoration.

COSMETIC PROCEDURES

Services and supplies that are primarily cosmetic in nature are not covered.

TEMPORARY SERVICES

Temporary dental services which are determined by the Fund to be an integral part of the final dental service rather than a separate service should be included in the allowance for the final service.

GENERAL ANESTHESIA / IV SEDATION

General anesthesia / IV sedation are only covered with covered oral surgery, implant placement and apicoectomy.



NEW YORK STATE (NYS)

These plans are for different divisions of NYS. All dental fee schedule allowances, orthodontic maximums, and annual maximums are the same.

\$2850 Annual Maximum



DUTCHESS
 \$3210 Annual Maximum

EQUINOX
 \$3210 Annual Maximum

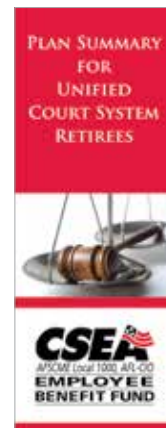
HORIZON
 \$3000 Annual Maximum

SUNRISE
 \$2850 Annual Maximum

SOLSTICE
 \$1800 Annual Maximum
 6 month waiting periods on prosthodontics & orthodontics.



UNIFIED COURT SYSTEM (UCS)
 \$3000 Annual Maximum



UCS RETIREES
 \$3000 Annual Maximum*



RETIREE
 \$1800 Annual Maximum

* Participating Providers are not required to accept these plan allowances as payment in full.

PLAN NAME »	NEW YORK STATE	RETIREE	UCS	UCS RETIREE
Calendar Year Max*	\$2850	\$1800	\$3000	\$3000
Adult Orthodontics	No	No	Yes	Yes
Consultation	1 / calendar year	1 / calendar year	1 / calendar year	1 / calendar year
Examination	3 / calendar year	3 / calendar year	3 / calendar year	2 / calendar year
Prophylaxis	3 / calendar year	3 / calendar year	3 / calendar year	2 / calendar year
Fluoride	2 / calendar year	2 / calendar year	2 / calendar year	2 / calendar year
Periapicals	10 per calendar year	10 per calendar year	10 per calendar year	10 per calendar year
Bitewings	4 per calendar year	4 per calendar year	4 per calendar year	4 per calendar year
Amalgams and Resin-Based Composite Fillings	1 per each surface per tooth per 12 months **THIS RULE IS FOR ALL AMALGAMS AND RESIN BASED COMPOSITES FOR ALL PLANS**			
Crowns	1 per 5 years	1 per 5 years	1 per 5 years	1 per 5 years
Root Canals	1 per tooth per lifetime	1 per tooth per lifetime	1 per tooth per lifetime	1 per tooth per lifetime
Gingivectomy	Each quad every 5 years	Each quad every 5 years	Each quad every 4 years	Each quad every 4 years
Osseous Surgery	Each quad every 5 years	Each quad every 5 years	Each quad every 4 years	Each quad every 4 years
Dentures	1 per 5 years	1 per 5 years	1 per 5 years	1 per 5 years
Bridges	1 per 5 years	1 per 5 years	1 per 5 years	1 per 5 years
Implants	1 per 10 years	None	1 per 10 years	None
Implant Crown/Bridge/Denture	1 per 10 years	1 per 10 years	1 per 10 years	1 per 10 years
Waiting Period	None	None	None	None

PLAN NAME »	DUTCHESS	EQUINOX	HORIZON	SUNRISE	SOLSTICE
Calendar Year Max*	\$3210	\$3210	\$3000	\$2850	\$1800
Adult Orthodontics	Yes	Yes	No	No	No
Consultation	1 / calendar year	1 / calendar year	1 / calendar year	1 / calendar year	1 / calendar year
Examination	3 / calendar year	3 / calendar year	3 / calendar year	3 / calendar year	3 / calendar year
Prophylaxis	3 / calendar year	3 / calendar year	3 / calendar year	3 / calendar year	3 / calendar year
Fluoride	2 / calendar year	2 / calendar year	2 / calendar year	2 / calendar year	2 / calendar year
Periapicals	10 per calendar year	10 per calendar year	10 per calendar year	10 per calendar year	10 per calendar year
Bitewings	4 per calendar year	4 per calendar year	4 per calendar year	4 per calendar year	4 per calendar year
Amalgams and Resin-Based Composite Fillings	1 per each surface per tooth per 12 months **THIS RULE IS FOR ALL AMALGAMS AND RESIN BASED COMPOSITES FOR ALL PLANS**				
Crowns	1 per 5 years	1 per 5 years	1 per 5 years	1 per 5 years	1 per 5 years
Root Canals	1 per tooth per lifetime	1 per tooth per lifetime	1 per tooth per lifetime	1 per tooth per lifetime	1 per tooth per lifetime
Gingivectomy	Each quad every 4 years	Each quad every 4 years	Each quad every 5 years	Each quad every 5 years	Each quad every 5 years
Osseous Surgery	Each quad every 4 years	Each quad every 4 years	Each quad every 5 years	Each quad every 5 years	Each quad every 5 years
Dentures	1 per 5 years	1 per 5 years	1 per 5 years	1 per 5 years	1 per 5 years
Bridges	1 per 5 years	1 per 5 years	1 per 5 years	1 per 5 years	1 per 5 years
Implants	1 per 10 years	1 per 10 years	1 per 10 years	1 per 10 years	None
Implant Crown/Bridge/Denture	1 per 10 years	1 per 10 years	1 per 10 years	1 per 10 years	1 per 10 years
Waiting Period	None	None	None	None	6 months on Orthodontics Prosthodontics

*As of 1/1/2014 there is no annual maximum for children under age 19 per the Affordable Care Act.

**DIAGNOSTIC SERVICES**

Consultation (1 per calendar year).....	\$100.00
Clinical Oral Evaluation (Examination)	
Evaluation – periodic, comprehensive, limited or detailed (3 per calendar year – outside annual maximum).....	\$40.00
Dental Radiographs	
Intraoral complete series, including bitewings (1 per 3 years)...	\$90.00
or	
Panoramic (1 per 3 years)	\$90.00
<i>There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed within the same 12 month period as a complete series. Periapical x-rays are not covered within the same 12 month period as a panoramic image.</i>	
Periapical x-ray, each image (Maximum 10 per calendar year)	\$10.00
Bitewing x-ray, each image (Maximum 4 per calendar year).....	\$10.00
Occlusal image (2 per 3 years)	\$20.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 yrs and over (3 per calendar year – outside annual maximum).....	\$78.00
Dental prophylaxis, child-under age 12 (3 per calendar year).....	\$63.00
Fluoride, child-under age 19 (2 per calendar year)	\$15.00
Sealants, child-under age 19, per tooth, covered on bicuspids and molars in the permanent dentition only (1 per 3 years).....	\$25.00
Space maintainers, under age 19 (1 per tooth per lifetime)	
Unilateral space maintainer.....	\$120.00
Bilateral space maintainer	\$176.00

RESTORATIVE (Fillings)

Amalgam Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, all adhesives, liners and bases and polishing to restore a tooth to proper form and function.</i>	
Permanent or Primary teeth	
Amalgam, one surface	\$90.00
Amalgam, two surfaces	\$115.00
Amalgam, three surfaces	\$135.00
Amalgam, four or more surfaces	\$145.00
Resin-Based Composite Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials called resin-based composites.</i>	
Permanent or Primary teeth (Anterior or Posterior)	
Resin based, one surface	\$90.00
Resin based, two surfaces	\$130.00
Resin based, three surfaces	\$145.00
Resin based, Four or more surfaces or involving incisal angle	\$145.00

RESTORATIVE (Crowns and Inlays/Onlays) Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the plan. Any type of crown restoration that has been in place for 12 months is considered permanent and subject to the frequency limitation. Benefits are payable upon insertion of the crown or inlay/onlay.

Pre-op radiographs are required for the review of this procedure.

Crowns (1 per 5 years)	
Resin (permanent, anterior teeth only).....	\$200.00
Resin fused to metal	\$490.00
Porcelain/Ceramic	\$725.00
Porcelain fused to metal	\$725.00
3/4 cast metal.....	\$280.00
Full cast metal.....	\$610.00

Implant/Abutment Supported Crowns (1 per 10 years)

Implant/abutment supported, porc/ceramic	\$725.00
Implant/abutment supported, porc fused to metal.....	\$725.00
Implant/abutment supported, full cast metal.....	\$610.00
Inlays/Onlays (1 per 5 years)	
Inlay/onlay, one surface	\$178.00
Inlay/onlay, two surfaces	\$208.00
Inlay/onlay, three or more surfaces.....	\$250.00
Other Restorative Services	
Recent crown, implant crown (1 per calendar year)	\$30.00
Stainless steel crown, deciduous teeth only (1 per tooth per 5 years).....	\$80.00
Pin retention, per tooth (1 per calendar year).....	\$20.00
Post and core, cast or prefabricated, per tooth (1 per 5 years).....	\$140.00

ENDODONTICS (Root Canal Therapy) (1 per tooth per lifetime)

<i>Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.</i>	
Root canal therapy, anterior	\$650.00
Root canal therapy, bicuspid	\$750.00
Root canal therapy, molar	\$900.00
Other Endodontic/Periradicular Services	
Pulpotomy, deciduous teeth only (1 per tooth per lifetime)	
Apicoectomy, 1st root (1 per tooth per lifetime)	\$575.00
Apicoectomy, each additional root.....	\$200.00
(General Anesthesia/IV Sedation covered with Apicoectomy)	
Retrograde filling, per root, in conjunction with Apicoectomy (1 per tooth per lifetime).....	\$125.00

PERIODONTICS *Gingivectomy, Osseous Surgery and Bone*

Replacement Graft will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. The treatment plan must be accompanied by x-rays and periodontal charting. Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity. There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Gingivectomy or gingivoplasty, per quadrant (1 per 5 years)	\$350.00
Osseous surgery, per quadrant (1 per 5 years)	\$700.00
Bone replacement graft, per tooth (D4263).....	\$250.00
Periodontal scaling and root planing, per quadrant (2 per calendar year, limited to 2 quadrants per visit)	\$60.00
Periodontal maintenance procedure (3 per calendar year – outside annual maximum), either prophylaxis or periodontal maintenance procedure	\$78.00

PROSTHODONTICS (Removable) A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next 5 or 10 year period. Benefits are payable only upon insertion of denture. Allowance includes post-delivery care, relines and adjustments for 6 months.

Complete Dentures (1 per 5 years)

Full upper or lower denture, permanent/immediate	\$900.00
Full upper or lower denture, interim.....	\$175.00
Partial Dentures (1 per 5 years)	
Partial upper or lower denture, permanent	\$900.00
Unilateral partial upper or lower denture, permanent	\$350.00
Interim partial dentures, upper or lower, anterior teeth only	\$175.00
Implant/Abutment Supported Dentures (1 per 10 years)	

Implant/abutment supported full upper or lower denture, permanent.....	\$900.00
Implant/abutment supported partial upper or lower denture, permanent.....	\$900.00
Repairs to Complete Dentures	
Replace missing or broken teeth (limited to 4 per calendar year).....	\$60.00
Repairs to Partial Dentures	
Repair, replace or add clasp to existing partial (limited to 4 per calendar year).....	\$60.00
Replace or add tooth to existing partial (limited to 4 per calendar year).....	\$60.00
Rebase Complete Denture (1 per 2 years)	
Rebase - upper or lower.....	\$250.00
Reline of Dentures - upper or lower (1 per 2 years)	
Reline complete denture.....	\$175.00
Reline partial denture.....	\$175.00

PROSTHODONTICS (Fixed) Services are limited to permanent teeth replacement. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.

Pontics (1 per 5 years)	
Cast metal.....	\$500.00
Porcelain fused to metal.....	\$600.00
Porcelain/Ceramic.....	\$600.00
Resin fused to metal.....	\$258.00
Abutment Crowns For Fixed Bridge Retainers (1 per 5 years)	
3/4 cast metal.....	\$425.00
Full cast metal.....	\$610.00
Porcelain fused to metal.....	\$725.00
Porcelain/Ceramic.....	\$725.00
Resin fused to metal.....	\$490.00
Retainer for Maryland-type bridge.....	\$290.00
Implant/Abutment Supported Crowns for Fixed Bridge Retainers (1 per 10 years)	
Implant/abutment supported, cast metal.....	\$610.00
Implant/abutment supported, porc fused to metal.....	\$725.00
Implant/abutment supported, porcelain/ceramic.....	\$725.00
Other Fixed Partial Denture Services	
Recent Bridge, Implant Bridge (1 per calendar year).....	\$80.00

ORAL SURGERY (Extractions) (1 per tooth per lifetime)	
Extract coronal remnants, primary tooth.....	\$75.00
Erupted tooth or exposed root.....	\$110.00
Surgical removal.....	\$175.00
Soft tissue impaction.....	\$300.00
Partial bony impaction.....	\$400.00
Full bony impaction.....	\$500.00
Surgical removal of residual roots.....	\$160.00

Other Oral Surgical Procedures

Surgical Placement of Implant Body-Proc. Code D6010 (1 per tooth position / per 10 years)

- An allowance will be provided for the surgical placement of the Implant Body. The plan will not pay for a replacement within the next 10 year period.
- A provider **either participating or non-participating** will be permitted to charge their customary fee for the implant body procedure and accept the \$1,000.00 per implant benefit as an **allowance** against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The allowance for the surgical implant body will be outside of the member's annual plan maximum.
- A tooth or teeth currently having a prosthetic (denture, partial denture, crown, inlay-only) placed within the last 5 years and is/ are being replaced by a covered **Implant/Abutment Supported Prosthetic** would be subject to the 5 year replacement rule.
- Implant/Abutment Supported Prosthetics - (Removable Dentures, Fixed Dentures, Fixed Partial Dentures/Retainers & Single

Crowns) will be subject to a 10 year replacement rule.

- Post-op Radiographs are required for the payment of this procedure. Benefits are payable upon insertion.

Implant Body (per tooth position) (2 teeth per calendar year).....\$1,000.00

Supporting Structures (1 per tooth position per 10 years/2 per calendar year)

Prefabricated Abutment (D6056).....\$250.00
Custom Abutment (D6057).....\$250.00

A provider either participating or non-participating will be permitted to charge their customary fee for the implant abutment and accept the \$250.00 per implant abutment benefit as an allowance against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.

- The allowance for the implant abutments will be outside of the member's annual plan maximum.

There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Bone Graft at time of implant placement (1 per tooth position per 10 years: D6104).....	\$350.00
Surgical access of an unerupted tooth (1 per tooth per lifetime).....	\$200.00
Biopsy of oral tissue, hard or soft (tissue removal).....	\$190.00
Alveoloplasty in conjunction with extractions, per quadrant (1 per lifetime).....	\$135.00
Alveoloplasty not in conjunction with extractions, per quadrant (1 per 5 years).....	\$135.00
Removal of odontogenic cyst or tumor.....	\$200.00
Removal of exostosis or torus, per site.....	\$300.00
Incision and drainage (intraoral, 1 per calendar year) General anesthesia/IV sedation not covered with this procedure.....	\$125.00
Frenulectomy.....	\$250.00
Excision of lesion (1 per calendar year).....	\$200.00
Bone replacement graft for ridge preservation (1 per tooth per lifetime: D7953).....	\$250.00

ORTHODONTICS *This plan does not cover adult orthodontics; appliances must be in place before age 19. Provided for employees and unmarried dependent children enrolled in the plan. If a cosmetic upgrade (ex. invisalign® or clear brackets) is chosen and treatment is provided by a participating provider, the member may be responsible for a one time cosmetic upgrade fee, to be discussed prior to treatment.*

Limited/Interceptive/Appliance Therapy.....\$300.00 (Once per lifetime, prior to and not in the same month as comprehensive treatment. Additional appliances and office visits are the responsibility of the member.)

Comprehensive Orthodontic Treatment, Appliance Insertion (once per lifetime).....\$1,000.00
Periodic Orthodontic Treatment Visit.....\$150.00

(A benefit is provided for 24 completed active monthly treatment visits per life. Treatment visits beyond 24 months are the responsibility of the member, at the CSEA EBF allowance rate, when treatment is provided by a participating provider.)

Passive Treatment (for cases started after 01/01/14) (one treatment benefit per lifetime following comprehensive treatment, includes retainers).....\$300.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation-each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit).....	\$100.00
or Intravenous sedation -each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit).....	\$100.00
Palliative (emergency) treatment of dental pain (2 per calendar year).....	\$60.00

**DIAGNOSTIC SERVICES**

Consultation (1 per calendar year).....	\$100.00
Clinical Oral Evaluation (Examination)	
Evaluation – periodic, comprehensive, limited or detailed (3 per calendar year-outside annual maximum)	\$38.00
Dental Radiographs	
Intraoral complete series, including bitewings (1 per 3 years).....	\$85.00
or	
Panoramic (1 per 3 years)	\$85.00
<i>There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed within the same 12 month period as a complete series. Periapical x-rays are not covered within the same 12 month period as a panoramic image.</i>	
Periapical x-ray, each image (Maximum 10 per calendar year)	\$8.00
Bitewing x-ray, each image (Maximum 4 per calendar year).....	\$10.00
Occlusal image (2 per 3 years).....	\$25.00
Cephalometric radiographic image (1 per calendar year).....	\$85.00
Tests and Laboratory Examinations	
Pulp vitality test (1 per tooth per calendar year).....	\$20.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 years and over (3 per calendar year-outside annual maximum)	\$75.00
Dental prophylaxis, child-under 12 years (3 per calendar year).....	\$60.00
Fluoride, child-under 19 years (2 per calendar year)	\$16.00
Sealants, child-under 19 years, per tooth, covered on bicuspid and molars in the permanent dentition only (1 per 3 years).....	\$22.00
Space maintainers, child-under age 19 (1 per tooth per lifetime)	
Unilateral space maintainer	\$78.00
Bilateral space maintainer	\$144.00

RESTORATIVE (Fillings)

Amalgam Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, all adhesives, liners and bases and polishing to restore a tooth to proper form and function.</i>	
Permanent or Primary teeth	
Amalgam, one surface	\$88.00
Amalgam, two surfaces	\$110.00
Amalgam, three surfaces	\$130.00
Amalgam, four or more surfaces	\$130.00
Resin-Based Composite Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials called resin-based composites.</i>	
Permanent or Primary teeth (Anterior or Posterior)	
Resin-based composite, one surface.....	\$95.00
Resin-based composite, two surfaces	\$120.00
Resin-based composite, three surfaces.....	\$150.00
Resin-based four or more surfaces or involving incisal angle	\$150.00

RESTORATIVE (Crowns and Inlays/Onlays) *Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the plan. Any type of crown restoration that has been in place for 12 months is considered permanent and subject to the frequency limitation. Benefits are payable upon insertion of the crown or inlay/onlay.*

Pre-op radiographs are required for the review of this procedure.

Crowns (1 per 5 years)	
Resin (permanent, anterior teeth only).....	\$180.00
Resin fused to metal	\$370.00
Porcelain/Ceramic	\$675.00
Porcelain fused to metal	\$675.00
3/4 cast metal.....	\$430.00

Full cast metal.....	\$500.00
Implant/Abutment Supported Crowns (1 per 10 years)	
Implant/abutment supported, porc/ceramic	\$675.00
Implant/abutment supported, porc fused to metal.....	\$675.00
Implant/abutment supported, full cast metal.....	\$500.00
Inlays/Onlays (1 per 5 years)	
Inlay/onlay, one surface	\$250.00
Inlay/onlay, two surfaces	\$370.00
Inlay/onlay, three or more surfaces.....	\$382.00
Other Restorative Services	
Recent Inlay (1 per calendar year).....	\$20.00
Recent Crown, Implant Crown (1 per calendar year).....	\$30.00
Stainless steel crown, deciduous teeth only (1 per tooth per 5 years).....	\$56.00
Core buildup, including pins (1 per tooth per lifetime).....	\$65.00
Pin retention, per tooth (1 per calendar year).....	\$20.00
Post and core, cast or prefabricated, per tooth (1 per 5 years).....	\$120.00

ENDODONTICS (Root Canal Therapy) (1 per tooth per lifetime)

<i>Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.</i>	
Root canal therapy, anterior	\$495.00
Root canal therapy, bicuspid.....	\$625.00
Root canal therapy, molar.....	\$775.00
Other Endodontic/Periradicular Services	
Pulp capping, direct or indirect (1 per calendar year).....	\$20.00
Pulpotomy, deciduous teeth only (1 per tooth per lifetime)	\$55.00
Apicoectomy, 1st root (1 per tooth per lifetime)	\$400.00
Apicoectomy, each additional root.....	\$125.00
<i>(General anesthesia /IV sedation covered with apicoectomy)</i>	
Retrograde filling, per root, in conjunction with apicoectomy (1 per tooth per lifetime).....	\$100.00

PERIODONTICS *Gingivectomy, Osseous Surgery and Bone*

*Replacement Graft will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. **The treatment plan must be accompanied by x-rays and periodontal charting.** Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity. There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.*

Gingivectomy or gingivoplasty, per quadrant (1 per 4 years).....	\$320.00
Osseous surgery, per quadrant (1 per 4 years).....	\$625.00
Bone replacement graft, per tooth (D4263)	\$250.00
Periodontal scaling and root planing, per quadrant (2 per calendar year, limited to 2 quadrants per visit)	\$90.00
Periodontal maintenance procedure (3 per calendar year-outside annual maximum), either prophylaxis or periodontal maintenance procedure	\$75.00

PROSTHODONTICS (Removable) *A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next 5 or 10 year period. Benefits are payable only upon insertion of denture. Allowance includes post-delivery care, relines and adjustments for 6 months.*

Complete Denture (1 per 5 years)

Full upper or lower denture, permanent/immediate	\$700.00
Partial Denture (1 per 5 years)	
Partial upper or lower denture, permanent	\$700.00
Unilateral partial upper or lower denture, permanent	\$300.00
Implant/Abutment Supported Dentures (1 per 10 years)	
Implant/abutment supported full upper	

Implant/abutment supported full upper or lower denture, permanent.....	\$700.00
Implant/abutment supported partial upper or lower denture, permanent.....	\$700.00
Adjustments to Dentures	
Full or Partial Denture Adjustment after 6 months of insertion of denture (1 per calendar year).....	\$30.00
Repairs to Complete Dentures	
Replace missing or broken teeth (limited to 4 per calendar year).....	\$50.00
Repairs to Partial Dentures	
Repair, replace or add clasp to existing partial (limited to 4 per calendar year).....	\$71.00
Replace or add tooth to existing partial (limited to 4 per calendar year).....	\$50.00
Rebase Complete Denture (1 per 2 years)	
Rebase - upper or lower.....	\$169.00
Reline of Dentures, upper or lower (1 per 2 years)	
Reline complete denture.....	\$154.00
Reline partial denture.....	\$154.00

PROSTHODONTICS (Fixed) Services are limited to permanent teeth replacement. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.

Pontics (1 per 5 years)	
Cast metal.....	\$425.00
Porcelain fused to metal.....	\$525.00
Porcelain/Ceramic.....	\$525.00
Resin fused to metal.....	\$346.00
Abutment Crowns for Fixed Bridge Retainers (1 per 5 years)	
3/4 Cast Metal.....	\$430.00
Full Cast metal.....	\$500.00
Porcelain fused to metal.....	\$675.00
Porcelain/Ceramic.....	\$675.00
Resin fused to metal.....	\$370.00
Retainer for Maryland-type bridge.....	\$230.00
Implant/Abutment Supported Crowns for Fixed Bridge Retainers (1 per 10 years)	
Implant/abutment supported, cast metal.....	\$500.00
Implant/abutment supported, porc fused to metal.....	\$675.00
Implant/abutment supported, porcelain/ceramic.....	\$675.00
Other Fixed Partial Denture Services	
Recent Bridge, Implant Bridge (1 per calendar year).....	\$50.00

ORAL SURGERY (Extractions) (1 per tooth per lifetime)	
Extract coronal remnants, primary tooth.....	\$80.00
Erupted tooth or exposed root.....	\$100.00
Surgical removal.....	\$140.00
Soft tissue impaction.....	\$230.00
Partial bony impaction.....	\$250.00
Full bony impaction.....	\$315.00
Surgical removal of residual roots.....	\$140.00

Other Oral Surgical Procedures

Surgical Placement of Implant Body-Proc. Code D6010 (1 per tooth position / per 10 years)

- An allowance will be provided for the surgical placement of the Implant Body. The plan will not pay for a replacement within the next 10 year period.
- A provider **either participating or non-participating** will be permitted to charge their customary fee for the implant body procedure and accept the \$1,000.00 per implant benefit as an **allowance** against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The allowance for the surgical implant body will be outside of the member's annual plan maximum.
- A tooth or teeth currently having a prosthetic (denture, partial denture, crown, inlay-only) placed within the last 5 years and is/ are being replaced by a covered **Implant/Abutment Supported**

Prosthetic would be subject to the 5 year replacement rule.

- Implant/Abutment Supported Prosthetics - (Removable Dentures, Fixed Dentures, Fixed Partial Dentures/Retainers & Single Crowns) will be subject to a 10 year replacement rule.
- Post-op Radiographs are required for the payment of this procedure. Benefits are payable upon insertion.

Implant Body (per tooth position)
(2 teeth per calendar year).....\$1,000.00

Supporting Structures (1 per tooth position per 10 years/2 per calendar year)

Prefabricated Abutment (D6056).....\$250.00
Custom Abutment (D6057).....\$250.00

A provider either participating or non-participating will be permitted to charge their customary fee for the implant abutment and accept the \$250.00 per implant abutment benefit as an allowance against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.

- The allowance for the implant abutments will be outside of the member's annual plan maximum.

There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Bone Graft at time of implant placement (1 per tooth position per 10 years: D6104).....	\$350.00
Surgical access of unerupted tooth (1 per tooth per lifetime).....	\$120.00
Biopsy of oral tissue, hard or soft (tissue removal).....	\$120.00
Alveoplasty in conjunction with extractions, per quadrant (1 per lifetime).....	\$135.00
Alveoplasty not in conjunction with extractions, per quadrant (1 per 5 years).....	\$100.00
Incision and drainage (intraoral, 1 per calendar year) General anesthesia/IV sedation not covered with this procedure.....	\$125.00
Frenulectomy.....	\$200.00
Excision of Lesion (1 per calendar year).....	\$200.00
Bone replacement graft for ridge preservation (1 per tooth per lifetime: D7953).....	\$250.00

ORTHODONTICS Provided for employees, spouses and unmarried dependent children enrolled in the plan. This plan covers adult orthodontics. If a cosmetic upgrade (ex. invisalign or clear brackets) is chosen and treatment is provided by a participating provider, the member may be responsible for a one time cosmetic upgrade fee, to be discussed prior to treatment.

Limited/Interceptive/Appliance Therapy.....\$300.00
(Once per lifetime, prior to and not in the same month as comprehensive treatment. Additional appliances and office visits are the responsibility of the member.)

Comprehensive orthodontic treatment, appliance insertion
(Once per lifetime).....\$808.00

Periodic orthodontic treatment visit.....\$125.00

(A benefit is provided for 24 completed active monthly treatment visits per life. Treatment visits beyond 24 months are the responsibility of the member, at the CSEA EBF allowance rate, when treatment is provided by a participating provider.)

Passive Treatment (for cases started after 01/01/14)
(one treatment benefit per lifetime following comprehensive treatment, includes retainers).....\$300.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation-each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit).....	\$100.00
or Intravenous sedation -each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit).....	\$100.00
Palliative (emergency) treatment of dental pain (2 per calendar year).....	\$50.00
Occlusal adjustment, limited (1 per 4 years).....	\$50.00
Occlusal adjustment, complete (1 per 4 years).....	\$175.00

**DIAGNOSTIC SERVICES**

Consultation (1 per calendar year).....	\$100.00
Clinical Oral Evaluation (Examination)	
Evaluation – periodic, comprehensive or detailed (only 2 exams per calendar year).....	\$30.00
Evaluation – limited (only 1 exam per 12 months).....	\$30.00
Dental Radiographs	
Intraoral complete series, including bitewings (1 per 3 years).....	\$80.00
or	
Panoramic (1 per 3 years).....	\$80.00
<i>There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed within the same 12 month period as a complete series. Periapical x-rays are not covered within the same 12 month period as a panoramic image.</i>	
Periapical x-ray, each image (Maximum 10 per calendar year).....	\$8.00
Bitewing x-ray, each image (Maximum 4 per calendar year).....	\$8.00
Occlusal image (2 per 3 years).....	\$25.00
Cephalometric radiographic image (1 per calendar year).....	\$80.00
Tests and Laboratory Examinations	
Pulp vitality test (1 per calendar year).....	\$6.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 yrs and over (2 per calendar year).....	\$61.00
Dental prophylaxis, child-under 12 yrs (2 per calendar year).....	\$39.00
Fluoride, child-under 19 years (2 per calendar year).....	\$14.00
Sealants, child-under age 19, per tooth, covered on bicuspids and molars in the permanent dentition only (1 per 3 years).....	\$17.00
Space maintainers, under age 19 (1 per tooth per lifetime)	
Unilateral, fixed space maintainer.....	\$60.00
Bilateral, fixed space maintainer.....	\$140.00
Unilateral, removable space maintainer.....	\$78.00
Bilateral, removable space maintainer.....	\$144.00

RESTORATIVE (Fillings)

Amalgam Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, all adhesives, liners and bases and polishing to restore a tooth to proper form and function.</i>	
Permanent or Primary teeth	
Amalgam, one surface.....	\$75.00
Amalgam, two surfaces.....	\$90.00
Amalgam, three surfaces.....	\$100.00
Amalgam, four or more surfaces.....	\$100.00
Resin-Based Composite Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials called resin-based composites.</i>	
Permanent or Primary teeth (Anterior or Posterior)	
Resin-based composite, one surface.....	\$80.00
Resin-based composite, two surfaces.....	\$95.00
Resin-based composite, three surfaces.....	\$110.00
Resin-based composite, four or more surfaces or involving incisal angle.....	\$110.00

RESTORATIVE (Crowns and Inlays/Onlays) *Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the plan. Any type of crown restoration that has been in place for 12 months is considered permanent and subject to the frequency limitation. Benefits are payable upon insertion of the crown or inlay/onlay.*

Pre-op radiographs are required for the review of this procedure.

Crowns (1 per 5 years)	
Resin (permanent, anterior teeth only).....	\$180.00
Resin fused to metal.....	\$325.00
Porcelain/Ceramic.....	\$340.00
Porcelain fused to metal.....	\$465.00

3/4 cast metal.....	\$325.00
Full cast metal.....	\$382.00
Implant/Abutment Supported Crowns (1 per 10 years)	
Implant/abutment supported, porc/ceramic.....	\$340.00
Implant/abutment supported, porc fused to metal.....	\$465.00
Implant/abutment supported, full cast metal.....	\$382.00
Inlays/Onlays (1 per 5 years)	
Inlay/onlay, one surface.....	\$150.00
Inlay/onlay, two surfaces.....	\$270.00
Inlay/onlay, three or more surfaces.....	\$288.00
Other Restorative Services	
Recent Inlay (1 per calendar year).....	\$12.00
Recent Crown, Implant Crown (1 per calendar year).....	\$26.00
Stainless steel crown, deciduous teeth (1 per tooth per 5 years).....	\$56.00
Core buildup, including pins (1 per tooth per lifetime).....	\$56.00
Pin retention, per tooth (1 per calendar year).....	\$18.00
Post and core, cast or prefabricated, per tooth (1 per 5 years).....	\$102.00

ENDODONTICS (Root Canal Therapy) (1 per tooth per lifetime)

<i>Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.</i>	
Root canal therapy, anterior.....	\$214.00
Root canal therapy, bicuspid.....	\$268.00
Root canal therapy, molar.....	\$377.00
Other Endodontic/Periradicular Services	
Pulp capping, direct or indirect (1 per calendar year).....	\$16.00
Pulpotomy, deciduous teeth only (1 per tooth per lifetime).....	\$31.00
Apicoectomy, 1st root (1 per tooth per lifetime).....	\$150.00
Apicoectomy, each additional root.....	\$100.00
(General anesthesia/IV sedation covered with apicoectomy)	
Retrograde filling, per root, in conjunction with apicoectomy (1 per tooth per lifetime).....	\$50.00

PERIODONTICS *Gingivectomy, Osseous Surgery and Bone Replacement Graft will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. The treatment plan must be accompanied by x-rays and periodontal charting. Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity. There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.*

Gingivectomy, or gingivoplasty per quadrant (1 per 4 years).....	
Osseous surgery, per quadrant (1 per 4 years).....	\$390.00
Bone replacement graft, per tooth (D4263).....	\$250.00
Periodontal scaling and root planing, per quadrant (2 per calendar year, limited to 2 quadrants per visit).....	\$27.00
Periodontal maintenance procedure (2 per calendar year, either prophylaxis or periodontal maintenance procedure).....	\$61.00

PROSTHODONTICS (Removable) *A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next 5 or 10 year period. Benefits are payable only upon insertion of denture. Allowance includes post-delivery care, relines and adjustments for 6 months.*

Complete Denture (1 per 5 years)	
Full upper or lower denture, permanent/immediate.....	\$420.00
Partial Denture (1 per 5 years)	
Partial upper or lower denture, permanent.....	\$450.00

Unilateral partial upper or lower denture, permanent.....	\$210.00
Implant/Abutment Supported Dentures (1 per 10 years)	
Implant/abutment supported full upper or lower denture, permanent.....	\$420.00
Implant/abutment supported partial upper or lower denture, permanent.....	\$450.00
Adjustments to Dentures	
Full or Partial Denture Adjustment after 6 months of insertion of denture (1 per calendar year).....	\$12.00
Repairs to Complete Dentures	
Replace missing or broken teeth (limited to 4 per calendar year).....	\$42.00
Repairs to Partial Dentures	
Repair, replace or add clasp to existing partial (limited to 4 per calendar year).....	\$71.00
Replace or add tooth to existing partial (limited to 4 per calendar year).....	\$42.00
Rebase Complete Dentures (1 per 2 years)	
Rebase upper or lower.....	\$94.00
Reline of Dentures Upper or Lower (1 per 2 years).	
Reline complete denture.....	\$150.00
Reline partial denture.....	\$150.00

PROSTHODONTICS (Fixed) Services are limited to permanent teeth replacement. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.

Pontics (1 per 5 years)	
Cast metal.....	\$164.00
Porcelain fused to metal.....	\$340.00
Porcelain/Ceramic.....	\$340.00
Resin fused to metal.....	\$270.00
Abutment Crowns For Fixed Bridge Retainers (1 per 5 years)	
3/4 cast metal.....	\$325.00
Full cast metal.....	\$382.00
Porcelain fused to metal.....	\$465.00
Porcelain/Ceramic.....	\$340.00
Resin fused to metal.....	\$325.00
Retainer for Maryland-type bridge.....	\$149.00
Implant/Abutment Supported Crowns for Fixed Bridge Retainers (1 per 10 years)	
Implant/abutment supported, cast metal.....	\$382.00
Implant/abutment supported, porc fused to metal.....	\$465.00
Implant/abutment supported, porcelain/ceramic.....	\$340.00
Other Fixed Partial Denture Services	
Recement Bridge, Implant Bridge (1 per calendar year).....	\$42.00

ORAL SURGERY (Extractions) (1 per tooth per lifetime)	
Extract coronal remnants, primary tooth.....	\$50.00
Erupted tooth or exposed root.....	\$50.00
Surgical removal.....	\$79.00
Soft tissue impaction.....	\$90.00
Partial bony impaction.....	\$126.00
Full bony impaction.....	\$175.00
Surgical removal of residual roots.....	\$60.00
Other Oral Surgical Procedures	
Surgical access of unerupted tooth (1 per tooth per lifetime).....	\$120.00
Biopsy of oral tissue, hard or soft, tissue removal.....	\$65.00
Alveoplasty in conjunction with extractions, per quadrant (1 per lifetime).....	\$47.00
Alveoplasty not in conjunction with extractions, per quadrant (1 per 5 years).....	\$86.00
Incision and drainage (intraoral, 1 per calendar year)	
General anesthesia/IV sedation not covered with this procedure.....	\$42.00
Frenulectomy.....	\$114.00

There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.
Bone Graft at time of implant placement (1 per tooth position per 10 years: D6104).....\$350.00
Bone replacement graft for ridge preservation (1 per tooth per lifetime: D7953).....\$250.00

ORTHODONTICS Provided for employees, spouses and unmarried dependent children enrolled in the plan. This plan covers adult orthodontics. If a cosmetic upgrade (ex. invisalign® or clear brackets) is chosen and treatment is provided by a participating provider, the member may be responsible for a one time cosmetic upgrade fee, to be discussed prior to treatment.

Limited/Interceptive/Appliance Therapy.....\$300.00
(Once per lifetime, prior to and not in the same month as comprehensive treatment. Additional appliances and office visits are the responsibility of the member.)

Comprehensive orthodontic treatment, appliance insertion (once per lifetime).....\$540.00
Periodic orthodontic treatment visit (A benefit is provided for 24 completed active monthly treatment visits per life. Treatment visits beyond 24 months are the responsibility of the member, at the CSEA EBF allowance rate, when treatment is provided by a participating provider.).....\$85.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation-each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit).....\$100.00
or Intravenous sedation -each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit).....\$100.00
Palliative (emergency) treatment of dental pain (2 per calendar year).....\$30.00
Occlusal adjustment, limited (1 per 4 years).....\$35.00
Occlusal adjustment, complete (1 per 4 years).....\$140.00

**DIAGNOSTIC SERVICES**

Consultation (1 per calendar year).....	\$100.00
Clinical Oral Evaluation (Examination)	
Evaluation – periodic, comprehensive, limited or detailed (3 per calendar year – outside annual maximum).....	\$48.00
Dental Radiographs	
Intraoral complete series, including bitewings (1 per 3 years).....	\$110.00
or	
Panoramic (1 per 3 years)	\$110.00
<i>There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed within the same 12 month period as a complete series. Periapical x-rays are not covered within the same 12 month period as a panoramic image.</i>	
Periapical x-ray, each image (Maximum 10 per calendar year)	\$12.00
Bitewing x-ray, each image (Maximum 4 per calendar year).....	\$12.00
Occlusal image (2 per 3 years).....	\$30.00
Cephalometric radiographic image (1 per calendar year).....	\$100.00
Tests and Laboratory Examinations	
Pulp vitality test (1 per calendar year).....	\$20.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 yrs and over (3 per calendar year – outside annual maximum).....	\$90.00
Dental prophylaxis, child-under 12 yrs (3 per calendar year) ...	\$75.00
Fluoride, child-under age 19 (2 per calendar year).....	\$20.00
Sealants, child-under age 19, per tooth covered on bicuspid and molars in the permanent dentition only. (1 per 3 years).....	\$28.00
Space maintainers, child-under age 19 (1 per tooth per lifetime)	
Unilateral space maintainer.....	\$100.00
Bilateral space maintainer	\$180.00

RESTORATIVE (Fillings)

Amalgam Restorations (1 per each surface per tooth per 12 month period). <i>Includes tooth preparation, all adhesives, liners and bases and polishing to restore a tooth to proper form and function.</i>	
Permanent or Primary teeth	
Amalgam, one surface	\$105.00
Amalgam, two surfaces	\$130.00
Amalgam, three surfaces	\$165.00
Amalgam, four or more surfaces	\$165.00
Resin-Based Composite Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials called resin-based composites.</i>	
Permanent or Primary teeth (Anterior or Posterior)	
Resin-based, one surface	\$110.00
Resin-based, two surfaces.....	\$145.00
Resin-based, three surfaces.....	\$185.00
Resin-based, four or more surfaces, or involving incisal angle.....	\$185.00

RESTORATIVE (Crowns and Inlays/Onlays) *Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the plan. Any type of crown restoration that has been in place for 12 months is considered permanent and subject to the frequency limitation. Benefits are payable upon insertion of the crown or inlay/onlay.*

Pre-op radiographs are required for the review of this procedure.

Crowns (1 per 5 years)	
Resin (permanent, anterior teeth only).....	\$200.00
Resin fused to metal	\$460.00
Porcelain/Ceramic	\$800.00

Porcelain fused to metal	\$800.00
3/4 cast metal.....	\$475.00
Full cast metal.....	\$675.00
Implant/Abutment Supported Crowns (1 per 10 years)	
Implant/abutment supported, porc/ceramic	\$800.00
Implant/abutment supported, porc fused to metal.....	\$800.00
Implant/abutment supported, full cast metal.....	\$675.00
Inlays/Onlays (1 per 5 years)	
Inlay/onlay, one surface	\$300.00
Inlay/onlay, two surfaces	\$420.00
Inlay/onlay, three or more surfaces.....	\$440.00
Other Restorative Services	
Recement inlay (1 per calendar year).....	\$20.00
Recement crown, implant crown (1 per calendar year)	\$45.00
Stainless Steel crowns, deciduous teeth only (1 per tooth per 3 years).....	\$75.00
Core buildup, per tooth, including pins (1 per tooth per lifetime)	\$75.00
Pin retention, per tooth (1 per calendar year).....	\$26.00
Post and core, cast or prefabricated, per tooth (1 per 5 years).....	\$165.00

ENDODONTICS (Root Canal Therapy) (1 per tooth per lifetime)

<i>Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.</i>	
Root canal therapy, anterior	\$675.00
Root canal therapy, bicuspid.....	\$825.00
Root canal therapy, molar.....	\$975.00
Other Endodontic/Periradicular Services	
Pulp capping, direct or indirect	
(1 per calendar year).....	\$20.00
Pulpotomy, deciduous teeth only (1 per tooth per lifetime)	\$75.00
Apicoectomy, 1st root (1 per tooth per lifetime)	\$630.00
Apicoectomy, each additional root.....	\$200.00
(General Anesthesia/IV Sedation covered with apicoectomy)	
Retrograde filling, per root, in conjunction with apicoectomy (1 per tooth per lifetime).....	\$135.00

PERIODONTICS *Gingivectomy, Osseous Surgery and Bone Replacement Graft will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. The treatment plan must be accompanied by x-rays and periodontal charting. Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity. There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.*

Gingivectomy or gingivoplasty, per quadrant (1 per 4 years) ...	\$400.00
Osseous surgery, per quadrant (1 per 4 years).....	\$750.00
Bone replacement graft, per tooth (D4263)	\$250.00
Periodontal scaling and root planing, per quadrant (2 per calendar year) limited to 2 quadrants per visit.....	\$100.00
Periodontal maintenance procedure (3 per calendar year – outside annual maximum), either prophylaxis or periodontal maintenance procedure.....	\$ 90.00

PROSTHODONTICS (Removable) *A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next 5 or 10 year period. Benefits are payable only upon insertion of denture. Allowance includes post-delivery care, relines and adjustments for 6 months.*

Complete Denture (1 per 5 years)	
Full upper or lower denture, permanent/immediate	\$950.00
Partial Denture (1 per 5 years)	
Partial upper or lower denture, permanent	\$950.00
Unilateral partial upper or lower denture, permanent.....	\$450.00

Interim partial denture, upper or lower, anterior teeth only...	\$250.00
Implant/Abutment Supported Dentures (1 per 10 years)	
Implant/abutment supported full upper or lower denture, permanent	\$950.00
Implant/abutment supported partial upper or lower denture, permanent	\$950.00
Adjustments to Dentures	
Full or Partial Denture Adjustment after 6 months of insertion of denture (1 per calendar year).....	\$50.00
Repairs to Complete Dentures	
Replace missing or broken teeth (limited to 4 per calendar year).....	\$75.00
Repairs to Partial Dentures	
Repair, replace or add clasp to existing partial (limited to 4 per calendar year).....	\$85.00
Replace or add tooth to existing partial (limited to 4 per calendar year).....	\$75.00
Rebase Complete Denture (1 per 2 years)	
Rebase upper or lower.....	\$250.00
Reline of Dentures upper or lower (1 per 3 years)	
Reline complete denture.....	\$200.00
Reline partial denture.....	\$200.00

PROSTHODONTICS (Fixed) Services are limited to permanent teeth replacement. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.

Pontics (1 per 5 years)	
Cast metal.....	\$525.00
Porcelain fused to metal	\$650.00
Porcelain/Ceramic	\$650.00
Resin fused to metal.....	\$425.00
Abutment Crowns For Fixed Bridge Retainers (1 per 5 years)	
3/4 cast metal.....	\$475.00
Full cast metal.....	\$675.00
Porcelain fused to metal	\$800.00
Porcelain/Ceramic	\$800.00
Resin fused to metal.....	\$460.00
Retainer for Maryland-type bridge	\$300.00
Implant/Abutment Supported Crowns for Fixed Bridge Retainers (1 per 10 years)	
Implant/abutment supported, cast metal.....	\$675.00
Implant/abutment supported, porc fused to metal.....	\$800.00
Implant/abutment supported, porcelain/ceramic.....	\$800.00
Other Fixed Partial Denture Services	
Recement bridge, implant bridge (1 per calendar year).....	\$80.00

ORAL SURGERY (Extractions) (1 per tooth per lifetime)

Extract coronal remnants, primary tooth	\$110.00
Erupted tooth or exposed root	\$160.00
Surgical removal.....	\$220.00
Soft tissue impaction.....	\$325.00
Partial bony impaction.....	\$425.00
Full bony impaction	\$525.00
Surgical removal of residual roots.....	\$220.00

Other Oral Surgical Procedures

Surgical Placement of Implant Body-Proc. Code D6010 (1 per tooth position / per 10 years)

- An allowance will be provided for the surgical placement of the Implant Body. The plan will not pay for a replacement within the next 10 year period.
- A provider **either participating or non-participating** will be permitted to charge their customary fee for the implant body procedure and accept the \$1,000.00 per implant benefit as an **allowance** against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The allowance for the surgical implant body will be outside of the member's annual plan maximum.
- A tooth or teeth currently having a prosthetic (denture, partial denture, crown, inlay-only) placed within the last 5 years and is/

are being replaced by a covered **Implant/Abutment Supported Prosthetic** would be subject to the 5 year replacement rule.

- Implant/Abutment Supported Prosthetics - (Removable Dentures, Fixed Dentures, Fixed Partial Dentures/Retainers & Single Crowns) will be subject to a 10 year replacement rule.
 - Post-op Radiographs are required for the payment of this procedure. Benefits are payable upon insertion.
- | | |
|--|------------|
| Implant Body (per tooth position) (2 teeth per calendar year) | \$1,000.00 |
| Supporting Structures (1 per tooth position per 10 years/2 per calendar year) | |
| Prefabricated Abutment (D6056)..... | \$250.00 |
| Custom Abutment (D6057)..... | \$250.00 |

A provider either participating or non-participating will be permitted to charge their customary fee for the implant abutment and accept the \$250.00 per implant abutment benefit as an allowance against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.

- The allowance for the implant abutments will be outside of the member's annual plan maximum.

There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Bone Graft at time of implant placement (1 per tooth position per 10 years: D6104).....	\$350.00
Surgical access of an unerupted tooth (Once per tooth per lifetime).....	\$300.00
Biopsy of oral tissue, hard or soft (tissue removal).....	\$175.00
Alveoplasty in conjunction with extractions, per quadrant (1 per lifetime).....	\$160.00
Alveoplasty not in conjunction with extractions, per quadrant (1 per 5 years).....	\$160.00
Incision and drainage (intraoral, 1 per calendar year) General anesthesia/IV sedation not covered with this procedure	\$125.00
Frenulectomy.....	\$250.00
Excision of lesion (1 per calendar year).....	\$200.00
Bone replacement graft for ridge preservation (1 per tooth per lifetime: D7953).....	\$250.00

ORTHODONTICS Provided for employees, spouses and unmarried dependent children enrolled in the plan. This plan covers adult orthodontics. If a cosmetic upgrade (ex. invisalign® or clear brackets) is chosen and treatment is provided by a participating provider, the member may be responsible for a one time cosmetic upgrade fee, to be discussed prior to treatment.

Limited/Interceptive/Appliance Therapy \$500.00 (Once per lifetime, prior to and not in the same month as comprehensive treatment. Additional appliances and office visits are the responsibility of the member.)

Comprehensive orthodontic treatment, appliance insertion (Once per lifetime) \$1,000.00
Periodic orthodontic treatment visit..... \$160.00

(A benefit is provided for 24 completed active monthly treatment visits per life. Treatment visits beyond 24 months are the responsibility of the member, at the EBF allowance rate, when treatment is provided by a participating provider.)

Passive Treatment (for cases started after 01/01/14) (one treatment benefit per lifetime following comprehensive treatment, includes retainers)..... \$300.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation-each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit).....	\$100.00
or	
Intravenous sedation -each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit)	\$100.00
Palliative (emergency) treatment of dental pain (2 per calendar year).....	\$64.00
Occlusal adjustment, limited (1 per 4 years)	\$50.00
Occlusal adjustment, complete (1 per 4 years).....	\$175.00

**DIAGNOSTIC SERVICES**

Consultation (1 per calendar year).....	\$100.00
Clinical Oral Evaluation (Examination)	
Evaluation – periodic, comprehensive, limited or detailed (3 per calendar year – outside annual maximum).....	\$45.00
Dental Radiographs	
Intraoral complete series, including bitewings (1 per 3 years).....	\$100.00
or	
Panoramic (1 per 3 years).....	\$100.00
<i>There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed within the same 12 month period as a complete series. Periapical x-rays are not covered within the same 12 month period as a panoramic image.</i>	
Periapical x-ray, each image (Maximum 10 per calendar year).....	\$12.00
Bitewing x-ray, each image (Maximum 4 per calendar year).....	\$10.00
Occlusal image (2 per 3 years).....	\$30.00
Cephalometric radiographic image (1 per calendar year).....	\$100.00
Tests and Laboratory Examinations	
Pulp vitality test (1 per calendar year).....	\$20.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 yrs and over (3 per calendar year – outside annual maximum).....	\$85.00
Dental prophylaxis, child-under 12 yrs (3 per calendar year).....	\$70.00
Fluoride, child-under age 19 (2 per calendar year).....	\$19.00
Sealants, child-under age 19, per tooth covered on bicuspid and molars in the permanent dentition only. (1 per 3 years).....	\$26.00
Space maintainers, child-under age 19 (1 per tooth per lifetime)	
Unilateral space maintainer.....	\$80.00
Bilateral space maintainer.....	\$160.00

RESTORATIVE (Fillings)

Amalgam Restorations (1 per each surface per tooth per 12 month period). <i>Includes tooth preparation, all adhesives, liners and bases and polishing to restore a tooth to proper form and function.</i>	
Permanent or Primary teeth	
Amalgam, one surface.....	\$100.00
Amalgam, two surfaces.....	\$125.00
Amalgam, three surfaces.....	\$155.00
Amalgam, four or more surfaces.....	\$155.00
Resin-Based Composite Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials called resin-based composites.</i>	
Permanent or Primary teeth (Anterior or Posterior)	
Resin-based, one surface.....	\$105.00
Resin-based, two surfaces.....	\$140.00
Resin-based, three surfaces.....	\$175.00
Resin-based, four or more surfaces, or involving incisal angle.....	\$175.00

RESTORATIVE (Crowns and Inlays/Onlays) *Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the plan. Any type of crown restoration that has been in place for 12 months is considered permanent and subject to the frequency limitation. Benefits are payable upon insertion of the crown or inlay/onlay.*

Pre-op radiographs are required for the review of this procedure.

Crowns (1 per 5 years)	
Resin (permanent, anterior teeth only).....	\$180.00
Resin fused to metal.....	\$450.00
Porcelain/Ceramic.....	\$775.00

Porcelain fused to metal.....	\$775.00
3/4 cast metal.....	\$455.00
Full cast metal.....	\$650.00
Implant/Abutment Supported Crowns (1 per 10 years)	
Implant/abutment supported, porc/ceramic.....	\$775.00
Implant/abutment supported, porc fused to metal.....	\$775.00
Implant/abutment supported, full cast metal.....	\$650.00
Inlays/Onlays (1 per 5 years)	
Inlay/onlay, one surface.....	\$275.00
Inlay/onlay, two surfaces.....	\$395.00
Inlay/onlay, three or more surfaces.....	\$410.00
Other Restorative Services	
Recent inlay (1 per calendar year).....	\$20.00
Recent crown, implant crown (1 per calendar year).....	\$40.00
Stainless steel crowns, deciduous teeth only (1 per tooth per 3 years).....	\$75.00
Core buildup, per tooth, including pins (1 per tooth per lifetime).....	\$75.00
Pin retention, per tooth (1 per calendar year).....	\$22.00
Post and core, cast or prefabricated, per tooth (1 per 5 years).....	\$160.00

ENDODONTICS (Root Canal Therapy) (1 per tooth per lifetime)

<i>Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.</i>	
Root canal therapy, anterior.....	\$625.00
Root canal therapy, bicuspid.....	\$775.00
Root canal therapy, molar.....	\$925.00
Other Endodontic/Periradicular Services	
Pulp capping, direct or indirect (1 per calendar year).....	\$20.00
Pulpotomy, deciduous teeth only (1 per tooth per lifetime).....	\$70.00
Apicoectomy, 1st root (1 per tooth per lifetime).....	\$620.00
Apicoectomy, each additional root.....	\$175.00
(General Anesthesia/IV Sedation covered with apicoectomy)	
Retrograde filling, per root, in conjunction with apicoectomy (1 per tooth per lifetime).....	\$130.00

PERIODONTICS *Gingivectomy, Osseous Surgery and Bone*

*Replacement Graft will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. **The treatment plan must be accompanied by x-rays and periodontal charting.** Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity. There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.*

Gingivectomy or gingivoplasty, per quadrant (1 per 4 years).....	\$375.00
Osseous surgery, per quadrant (1 per 4 years).....	\$725.00
Bone replacement graft, per tooth (D4263).....	\$250.00
Periodontal scaling and root planing, per quadrant (2 per calendar year limited to 2 quadrants per visit).....	\$100.00
Periodontal maintenance procedure (3 per calendar year – outside annual maximum), either prophylaxis or periodontal maintenance procedure.....	\$85.00

PROSTHODONTICS (Removable) *A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next 5 or 10 year period. Benefits are payable only upon insertion of denture. Allowance includes post-delivery care, relines and adjustments for 6 months.*

Complete Denture (1 per 5 years)	
Full upper or lower denture, permanent/immediate.....	\$950.00
Partial Denture (1 per 5 years)	
Partial upper or lower denture, permanent.....	\$950.00
Unilateral partial upper or lower denture, permanent.....	\$425.00

Interim partial denture, upper or lower, anterior teeth only...	\$230.00
Implant/Abutment Supported Dentures (1 per 10 years)	
Implant/abutment supported full upper or lower denture, permanent	\$950.00
Implant/abutment supported partial upper or lower denture, permanent	\$950.00
Adjustments to Dentures	
Full or Partial Denture Adjustment after 6 months of insertion of denture (1 per calendar year).....	\$50.00
Repairs to Complete Dentures	
Replace missing or broken teeth (limited to 4 per calendar year).....	\$60.00
Repairs to Partial Dentures	
Repair, replace or add clasp to existing partial (limited to 4 per calendar year).....	\$75.00
Replace or add tooth to existing partial (limited to 4 per calendar year).....	\$60.00
Rebase Complete Denture (1 per 2 years)	
Rebase upper or lower.....	\$225.00
Reline of Dentures upper or lower (1 per 3 years)	
Reline complete denture.....	\$190.00
Reline partial denture.....	\$190.00

PROSTHODONTICS (Fixed) Services are limited to permanent teeth replacement. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.

Pontics (1 per 5 years)	
Cast metal.....	\$525.00
Porcelain fused to metal	\$625.00
Porcelain/Ceramic	\$625.00
Resin fused to metal.....	\$400.00
Abutment Crowns For Fixed Bridge Retainers (1 per 5 years)	
3/4 cast metal.....	\$455.00
Full cast metal.....	\$650.00
Porcelain fused to metal	\$775.00
Porcelain/Ceramic	\$775.00
Resin fused to metal.....	\$450.00
Retainer for Maryland-type bridge	\$285.00
Implant/Abutment Supported Crowns for Fixed Bridge Retainers (1 per 10 years)	
Implant/abutment supported, cast metal.....	\$650.00
Implant/abutment supported, porc fused to metal.....	\$775.00
Implant/abutment supported, porcelain/ceramic.....	\$775.00
Other Fixed Partial Denture Services	
Recement bridge, implant bridge (1 per calendar year).....	\$75.00

ORAL SURGERY (Extractions) (1 per tooth per lifetime)

Extract coronal remnants, primary tooth	\$100.00
Erupted tooth or exposed root	\$140.00
Surgical removal.....	\$200.00
Soft tissue impaction.....	\$325.00
Partial bony impaction.....	\$375.00
Full bony impaction.....	\$425.00
Surgical removal of residual roots.....	\$200.00

Other Oral Surgical Procedures

Surgical Placement of Implant Body-Proc. Code D6010 (1 per tooth position / per 10 years)

- An allowance will be provided for the surgical placement of the Implant Body. The plan will not pay for a replacement within the next 10 year period.
- A provider **either participating or non-participating** will be permitted to charge their customary fee for the implant body procedure and accept the \$1,000.00 per implant benefit as an allowance against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The **allowance** for the surgical implant body will be outside of the member's annual plan maximum.
- A tooth or teeth currently having a prosthetic (denture, partial denture, crown, inlay-onlay) placed within the last 5 years and is/

are being replaced by a covered **Implant/Abutment Supported Prosthetic** would be subject to the 5 year replacement rule.

- Implant/Abutment Supported Prosthetics-(Removable Dentures, Fixed Dentures, Fixed Partial Dentures/Retainers & Single Crowns) will be subject to a 10 year replacement rule.
 - Post-op Radiographs are required for the payment of this procedure. Benefits are payable upon insertion.
- | | |
|--|------------|
| Implant Body (per tooth position) (2 teeth per calendar year) | \$1,000.00 |
| Supporting Structures (1 per tooth position per 10 years/2 per calendar year) | |
| Prefabricated Abutment (D6056)..... | \$250.00 |
| Custom Abutment (D6057)..... | \$250.00 |

A provider either participating or non-participating will be permitted to charge their customary fee for the implant abutment and accept the \$250.00 per implant abutment benefit as an allowance against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.

- The allowance for the implant abutments will be outside of the member's annual plan maximum.

There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Bone Graft at time of implant placement (1 per tooth position per 10 years: D6104).....	\$350.00
Surgical access of an unerupted tooth (1 per tooth per lifetime).....	\$275.00
Biopsy of oral tissue, hard or soft (tissue removal).....	\$150.00
Alveoplasty in conjunction with extractions, per quadrant (1 per lifetime)	\$160.00
Alveoplasty not in conjunction with extractions, per quadrant (1 per 5 years).....	\$160.00
Incision and drainage (intraoral, 1 per calendar year) General Anesthesia/IV sedation not covered with this procedure.....	\$125.00
Frenulectomy.....	\$225.00
Excision of lesion (1 per calendar year).....	\$200.00
Bone replacement graft for ridge preservation (1 per tooth per lifetime: D7953).....	\$250.00

ORTHODONTICS *Provided for employees, spouses and unmarried dependent children enrolled in the plan. This plan covers adult orthodontics. If a cosmetic upgrade (ex. invisalign® or clear brackets) is chosen and treatment is provided by a participating provider, the member may be responsible for a one time cosmetic upgrade fee, to be discussed prior to treatment.*

Limited/Interceptive/Appliance Therapy \$500.00 (Once per lifetime, prior to and not in the same month as comprehensive treatment. Additional appliances and office visits are the responsibility of the member.)

Comprehensive orthodontic treatment, appliance insertion (Once per lifetime)

Periodic orthodontic treatment visit..... \$155.00

(A benefit is provided for 24 completed active monthly treatment visits per life. Treatment visits beyond 24 months are the responsibility of the member, at the Fund allowance rate, when treatment is provided by a participating provider.)

Passive treatment (for cases started after 01/01/14) (one treatment benefit per lifetime following comprehensive treatment, includes retainers)..... \$300.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation-each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit)..... \$100.00 or

Intravenous sedation -each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit)

Palliative (emergency) treatment of dental pain (2 per calendar year)..... \$60.00
Occlusal adjustment, limited (1 per 4 years)..... \$50.00
Occlusal adjustment, complete (1 per 4 years)..... \$175.00

**DIAGNOSTIC SERVICES**

Consultation (1 per calendar year).....	\$100.00
Clinical Oral Evaluation (Examination)	
Evaluation – periodic, comprehensive, limited or detailed (3 per calendar year – outside annual maximum).....	\$42.00
Dental Radiographs	
Intraoral complete series, including bitewings (1 per 3 years).....	\$85.00
or	
Panoramic (1 per 3 years).....	\$85.00
<i>There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed within the same 12 month period as a complete series. Periapical x-rays are not covered within the same 12 month period as a panoramic image.</i>	
Periapical x-ray, each image (Maximum 10 per calendar year).....	\$10.00
Bitewing x-ray, each image (Maximum 4 per calendar year).....	\$10.00
Occlusal image (2 per 3 years).....	\$25.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 yrs and over (3 per calendar year – outside annual maximum).....	\$80.00
Dental prophylaxis, child-under 12 yrs (3 per calendar year).....	\$65.00
Fluoride, child-under age 19 (2 per calendar year).....	\$18.00
Sealants, child-under age 19, per tooth covered on bicuspid and molars in the permanent dentition only. (1 per 3 years).....	\$25.00
Space maintainers, child-under age 19 (1 per tooth per lifetime)	
Unilateral space maintainer.....	\$75.00
Bilateral space maintainer.....	\$150.00

RESTORATIVE (Fillings)

Amalgam Restorations (1 per each surface per tooth per 12 month period). <i>Includes tooth preparation, all adhesives, liners and bases and polishing to restore a tooth to proper form and function.</i>	
Permanent or Primary teeth	
Amalgam, one surface.....	\$94.00
Amalgam, two surfaces.....	\$120.00
Amalgam, three surfaces.....	\$150.00
Amalgam, four or more surfaces.....	\$150.00
Resin-Based Composite Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials called resin-based composites.</i>	
Permanent or Primary teeth (Anterior or Posterior)	
Resin-based, one surface.....	\$100.00
Resin-based, two surfaces.....	\$135.00
Resin-based, three surfaces.....	\$165.00
Resin-based, four or more surfaces, or involving incisal angle.....	\$165.00

RESTORATIVE (Crowns and Inlays/Onlays) *Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the plan. Any type of crown restoration that has been in place for 12 months is considered permanent and subject to the frequency limitation. Benefits are payable upon insertion of the crown or inlay/onlay.*

Pre-op radiographs are required for the review of this procedure.**Crowns** (1 per 5 years)

Resin (permanent, anterior teeth only).....	\$160.00
Resin fused to metal.....	\$425.00
Porcelain/Ceramic.....	\$750.00
Porcelain fused to metal.....	\$750.00

3/4 cast metal.....	\$430.00
Full cast metal.....	\$625.00
Implant/Abutment Supported Crowns (1 per 10 years)	
Implant/abutment supported, porc/ceramic.....	\$750.00
Implant/abutment supported, porc fused to metal.....	\$750.00
Implant/abutment supported, full cast metal.....	\$625.00
Inlays/Onlays (1 per 5 years)	
Inlay/onlay, one surface.....	\$250.00
Inlay/onlay, two surfaces.....	\$370.00
Inlay/onlay, three or more surfaces.....	\$382.00
Other Restorative Services	
Recent crown, implant crown (1 per calendar year).....	\$35.00
Stainless Steel crowns, deciduous teeth only (1 per tooth per 3 years).....	\$75.00
Pin retention, per tooth (1 per calendar year).....	\$20.00
Post and core, cast or prefabricated, per tooth (1 per 5 years).....	\$155.00

ENDODONTICS (Root Canal Therapy) (1 per tooth per lifetime)

Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.	
Root canal therapy, anterior.....	\$600.00
Root canal therapy, bicuspid.....	\$650.00
Root canal therapy, molar.....	\$800.00
Other Endodontic/Periradicular Services	
Pulpotomy, deciduous teeth only (1 per tooth per lifetime).....	\$65.00
Apicoectomy, 1st root (1 per tooth per lifetime).....	\$600.00
Apicoectomy, each additional root.....	\$150.00
(General Anesthesia/IV sedation covered with Apicoectomy)	
Retrograde filling, per root, in conjunction with apicoectomy (1 per tooth per lifetime).....	\$125.00

PERIODONTICS *Gingivectomy, Osseous Surgery and Bone*

Replacement Graft will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. The treatment plan must be accompanied by x-rays and periodontal charting. Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity. There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Gingivectomy or gingivoplasty per quadrant (1 per 5 years).....	\$350.00
Osseous surgery, per quadrant (1 per 5 years).....	\$675.00
Bone replacement graft, per tooth (D4263).....	\$250.00
Periodontal scaling and root planing, per quadrant (2 per calendar year, limited to 2 quadrants per visit).....	\$100.00
Periodontal maintenance procedure (3 per calendar year – outside annual maximum), either prophylaxis or periodontal maintenance procedure.....	\$80.00

PROSTHODONTICS (Removable) *A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next 5 or 10 year period. Benefits are payable only upon insertion of denture. Allowance includes post-delivery care, relines and adjustments for 6 months.*

Complete Dentures (1 per 5 years)

Full upper or lower denture, permanent/immediate.....	\$925.00
Full upper or lower denture, interim.....	\$220.00
Partial Dentures (1 per 5 years)	
Partial upper or lower denture, permanent.....	\$925.00
Unilateral partial upper or lower denture, permanent.....	\$400.00
Interim partial denture, upper or lower, anterior teeth only.....	\$220.00

Implant/Abutment Supported Dentures (1 per 10 years)

Implant/abutment supported full upper or lower denture, permanent\$925.00

Implant/abutment supported partial upper or lower denture, permanent\$925.00

Repairs to Complete Dentures

Replace missing or broken teeth (limited to 4 per calendar year)\$60.00

Repairs to Partial Dentures

Repair, replace or add clasp to existing partial (limited to 4 per calendar year)\$65.00

Replace or add tooth to existing partial (limited to 4 per calendar year)\$60.00

Rebase Complete Denture (1 per 2 years)

Rebase - upper or lower\$200.00

Reline of Dentures, Upper or Lower (1 per 2 years)

Reline complete denture\$180.00

Reline partial denture\$180.00

PROSTHODONTICS (Fixed) *Services are limited to permanent teeth replacement. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.*

Pontics (1 per 5 years)

Cast metal\$500.00

Porcelain fused to metal\$600.00

Porcelain/Ceramic\$600.00

Resin fused to metal\$375.00

Abutment Crowns For Fixed Bridge Retainers (1 per 5 years)

3/4 cast metal\$430.00

Full cast metal\$625.00

Porcelain fused to metal\$750.00

Porcelain/Ceramic\$750.00

Resin fused to metal\$425.00

Retainer for Maryland-type bridge\$275.00

Implant/Abutment Supported Crowns for Fixed Bridge Retainers (1 per 10 years)

Implant/abutment supported, cast metal\$625.00

Implant/abutment supported, porc fused to metal\$750.00

Implant/abutment supported, porcelain/ceramic\$750.00

Other Fixed Partial Denture Services

Recent bridge, implant bridge (1 per calendar year)\$65.00

ORAL SURGERY (Extractions) (1 per tooth per lifetime)

Extract coronal remnants, primary tooth\$90.00

Erupted tooth or exposed root\$120.00

Surgical removal\$180.00

Soft tissue impaction\$275.00

Partial bony impaction\$350.00

Full bony impaction\$400.00

Surgical removal of residual roots\$180.00

Other Oral Surgical Procedures

Surgical Placement of Implant Body-Proc. Code D6010 (1 per tooth position / per 10 years)

- An allowance will be provided for the surgical placement of the Implant Body. The plan will not pay for a replacement within the next 10 year period.
- A provider **either participating or non-participating** will be permitted to charge their customary fee for the implant body procedure and accept the \$1,000.00 per implant benefit as an **allowance** against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The allowance for the surgical implant body will be outside of the member's annual plan maximum.
- A tooth or teeth currently having a prosthetic (denture, partial denture, crown, inlay-only) placed within the last 5 years and is/ are being replaced by a covered **Implant/Abutment Supported Prosthetic** would be subject to the 5 year replacement rule.
- Implant/Abutment Supported Prosthetics - (Removable Dentures,

Fixed Dentures, Fixed Partial Dentures/Retainers & Single Crowns) will be subject to a 10 year replacement rule.

- Post-op Radiographs are required for the payment of this procedure. Benefits are payable upon insertion.

Implant Body (per tooth position)
(2 teeth per calendar year)\$1,000.00

Supporting Structures (1 per tooth position per 10 years/2 per calendar year)

Prefabricated Abutment (D6056)\$250.00

Custom Abutment (D6057)\$250.00

A provider either participating or non-participating will be permitted to charge their customary fee for the implant abutment and accept the \$250.00 per implant abutment benefit as an allowance against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.

- The allowance for the implant abutments will be outside of the member's annual plan maximum.

There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Bone Graft at time of implant placement
(1 per tooth position per 10 years: D6104)\$350.00

Biopsy of oral tissue, hard or soft (tissue removal)\$140.00

Alveoplasty in conjunction with extractions,
per quadrant (1 per lifetime)\$150.00

Alveoplasty not in conjunction with extractions,
per quadrant (1 per 5 years)\$150.00

Removal of odontogenic cyst or tumor\$200.00

Removal of exostosis or torus, per site\$200.00

Incision and drainage (intraoral, 1 per calendar year)
General anesthesia/IV sedation not covered
with this procedure\$125.00

Frenulectomy\$225.00

Excision of lesion (1 per calendar year)\$200.00

Bone replacement graft for ridge preservation
(1 per tooth per lifetime: D7953)\$250.00

ORTHODONTICS *This plan does not cover adult orthodontics; appliances must be in place before age 19. Provided for employees and unmarried dependent children enrolled in the plan. If a cosmetic upgrade (ex. invisalign® or clear brackets) is chosen and treatment is provided by a participating provider, the member may be responsible for a one time cosmetic upgrade fee, to be discussed prior to treatment.*

Limited/Interceptive/Appliance Therapy\$500.00
(Once per lifetime, prior to and not in the same month as comprehensive treatment. Additional appliances and office visits are the responsibility of the member.)

Comprehensive orthodontic treatment, appliance insertion
(Once per lifetime)\$975.00

Periodic orthodontic treatment visit\$150.00
(A benefit is provided for 24 completed active monthly treatment visits per life. Treatment visits beyond 24 months are the responsibility of the member, at the EBF allowance rate, when treatment is provided by a participating provider.)

Passive orthodontic treatment visit
(for cases started after 01/01/14)
(one treatment benefit per lifetime following comprehensive treatment, includes retainers)\$300.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation-each 15 minute increment with a maximum benefit of \$200.00
(per covered oral surgery visit)\$100.00
or

Intravenous sedation -each 15 minute increment with a maximum benefit of \$200.00
(per covered oral surgery visit)\$100.00

Palliative (emergency) treatment of dental pain
(2 per calendar year)\$58.00

**DIAGNOSTIC SERVICES**

Consultation (1 per calendar year).....	\$100.00
Clinical Oral Evaluation (Examination)	
Evaluation – periodic, comprehensive, limited or detailed (3 per calendar year – outside annual maximum).....	\$34.00
Dental Radiographs	
Intraoral complete series, including bitewings (1 per 3 years).....	\$85.00
or	
Panoramic (1 per 3 years).....	\$85.00
<i>There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed within the same 12 month period as a complete series. Periapical x-rays are not covered within the same 12 month period as a panoramic image.</i>	
Periapical x-ray, each image (Maximum 10 per calendar year).....	\$8.00
Bitewing x-ray, each image (Maximum 4 per calendar year).....	\$10.00
Occlusal image (2 per 3 years).....	\$25.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 yrs and over (3 per calendar year – outside annual maximum).....	\$75.00
Dental prophylaxis, child-under age 12 (3 per calendar year).....	\$60.00
Fluoride, child-under age 19 (2 per calendar year).....	\$17.00
Sealants, child-under age 19, per tooth, covered on bicuspid and molars in the permanent dentition only (1 per 3 years).....	\$24.00
Space maintainers, child-under age 19 (1 per tooth per lifetime)	
Unilateral space maintainer.....	\$70.00
Bilateral space maintainer.....	\$125.00

RESTORATIVE (Fillings)

Amalgam Restorations (1 per each surface per tooth per 12 month period). <i>Includes tooth preparation, all adhesives, liners and bases and polishing to restore a tooth to proper form and function.</i>	
Permanent or Primary Teeth	
Amalgam, one surface.....	\$88.00
Amalgam, two surface.....	\$110.00
Amalgam, three surfaces.....	\$145.00
Amalgam, four or more surfaces.....	\$145.00
Resin-Based Composite Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials called resin-based composites.</i>	
Permanent or Primary teeth (Anterior or Posterior)	
Resin-based, one surface.....	\$95.00
Resin-based, two surfaces.....	\$125.00
Resin-based, three surfaces.....	\$155.00
Resin-based four or more surfaces, or involving incisal angle.....	\$155.00

RESTORATIVE (Crowns and Inlays/Onlays) *Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the plan. Any type of crown restoration that has been in place for 12 months is considered permanent and subject to the frequency limitation. Benefits are payable upon insertion of the crown or inlay/onlay.*

Pre-op radiographs are required for the review of this procedure.

Crowns (1 per 5 years)	
Resin (permanent, anterior teeth only).....	\$155.00
Resin fused to metal.....	\$375.00
Porcelain/Ceramic.....	\$725.00
Porcelain fused to metal.....	\$725.00

3/4 cast metal.....	\$425.00
Full cast metal.....	\$575.00
Implant/Abutment Supported Crowns (1 per 10 years)	
Implant/abutment supported, porc/ceramic.....	\$725.00
Implant/abutment supported, porc fused to metal.....	\$725.00
Implant/abutment supported, full cast metal.....	\$575.00
Inlays/Onlays (1 per 5 years)	
Inlay/onlay, one surface.....	\$243.00
Inlay/onlay, two surfaces.....	\$293.00
Inlay/onlay, three or more surfaces.....	\$307.00
Other Restorative Services	
Recent crown, implant crown (1 per calendar year).....	\$30.00
Stainless Steel crowns, deciduous teeth only (1 per tooth per 3 years).....	\$75.00
Pin retention - per tooth (1 per calendar year).....	\$20.00
Post and core, cast or prefabricated, per tooth (1 per 5 years).....	\$150.00

ENDODONTICS (Root Canal Therapy) (1 per tooth per lifetime)

Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.

Root canal therapy, anterior.....	\$550.00
Root canal therapy, bicuspid.....	\$650.00
Root canal therapy, molar.....	\$775.00
Other Endodontic/Periradicular Services	
Pulpotomy, deciduous teeth only (1 per tooth per lifetime).....	\$60.00
Apicoectomy, 1st root (1 per tooth per lifetime).....	\$400.00
Apicoectomy, each additional root.....	\$125.00
<i>(General Anesthesia/IV Sedation covered with Apicoectomy)</i>	
Retrograde filling, per root, in conjunction with apicoectomy (1 per tooth per lifetime).....	\$100.00

PERIODONTICS *Gingivectomy, Osseous Surgery and Bone*

Replacement Graft will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. The treatment plan must be accompanied by x-rays and periodontal charting. Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity. There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Gingivectomy or gingivoplasty, per quadrant (1 per 5 years).....	\$325.00
Osseous surgery, per quadrant (1 per 5 years).....	\$650.00
Bone replacement graft, per tooth (D4263).....	\$250.00
Periodontal scaling and root planing, per quadrant (2 per calendar year, limited to 2 quadrants per visit).....	\$100.00
Periodontal maintenance procedure (3 per calendar year – outside annual maximum), either prophylaxis or periodontal maintenance procedure.....	\$ 75.00

PROSTHODONTICS (Removable) *A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next 5 or 10 year period. Benefits are payable only upon insertion of denture. Allowance includes post-delivery care, relines and adjustments for 6 months.*

Complete Denture (1 per 5 years)	
Full upper or lower denture, permanent/immediate.....	\$900.00
Full upper or lower denture, interim.....	\$200.00
Partial Dentures (1 per 5 years)	
Partial upper or lower denture, permanent.....	\$900.00
Unilateral partial upper or lower denture, permanent.....	\$350.00
Interim partial denture, upper or lower, anterior teeth only.....	\$200.00

Implant/Abutment Supported Dentures (1 per 10 years)

Implant/abutment supported full upper or lower denture, permanent	\$900.00
Implant/abutment supported partial upper or lower denture, permanent	\$900.00

Repairs to Complete Dentures

Replace missing or broken teeth (limited to 4 per calendar year)	\$60.00
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Repairs to Partial Dentures

Repair, replace or add clasp to existing partial (limited to 4 per calendar year)	\$65.00
Replace or add tooth to existing partial (limited to 4 per calendar year)	\$60.00

Rebase Complete Denture (1 per 2 years)

Rebase-upper or lower	\$200.00
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Reline of Dentures, Upper or Lower (1 per 2 years)

Reline complete denture	\$175.00
Reline partial denture	\$175.00

PROSTHODONTICS (Fixed) *Services are limited to permanent teeth replacement. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.*

Pontics (1 per 5 years)

Cast metal, full	\$450.00
Porcelain fused to metal	\$550.00
Porcelain/Ceramic	\$550.00
Resin fused to metal	\$300.00

Abutment Crowns For Fixed Bridge Retainers (1 per 5 years)

3/4 cast metal	\$425.00
Full cast metal	\$575.00
Porcelain fused to metal	\$725.00
Porcelain/Ceramic	\$725.00
Resin fused to metal	\$375.00
Retainer for Maryland-type bridge	\$250.00

Implant/Abutment Supported Crowns for Fixed Bridge Retainers (1 per 10 years)

Implant/abutment supported, cast metal	\$575.00
Implant/abutment supported, porc fused to metal	\$725.00
Implant/abutment supported, porcelain/ceramic	\$725.00

Other Fixed Partial Denture Services

Recent bridge, implant bridge (1 per calendar year)	\$65.00
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ORAL SURGERY (Extractions) (1 per tooth per lifetime)

Extract coronal remnants, primary tooth	\$80.00
Erupted tooth or exposed root	\$110.00
Surgical removal	\$160.00
Soft tissue impaction	\$250.00
Partial bony impaction	\$300.00
Full bony impaction	\$375.00
Surgical removal of residual roots	\$160.00

Other Oral Surgical Procedures

Surgical Placement of Implant Body-Proc. Code D6010 (1 per tooth position / per 10 years)

- An allowance will be provided for the surgical placement of the Implant Body. The plan will not pay for a replacement within the next 10 year period.
- A provider **either participating or non-participating** will be permitted to charge their customary fee for the implant body procedure and accept the \$1,000.00 per implant benefit as an **allowance** against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The allowance for the surgical implant body will be outside of the member's annual plan maximum.
- A tooth or teeth currently having a prosthetic (denture, partial denture, crown, inlay-only) placed within the last 5 years and is/are being replaced by a covered **Implant/Abutment Supported Prosthetic** would be subject to the 5 year replacement rule.

- Implant/Abutment Supported Prosthetics - (Removable Dentures, Fixed Dentures, Fixed Partial Dentures/Retainers & Single Crowns) will be subject to a 10 year replacement rule.
- Post-op Radiographs are required for the payment of this procedure. Benefits are payable upon insertion.

Implant Body (per tooth position)

(2 teeth per calendar year)	\$1,000.00
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Supporting Structures (1 per tooth position per 10 years/2 per calendar year)

Prefabricated Abutment (D6056)	\$250.00
Custom Abutment (D6057)	\$250.00

A provider either participating or non-participating will be permitted to charge their customary fee for the implant abutment and accept the \$250.00 per implant abutment benefit as an allowance against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.

- The allowance for the implant abutments will be outside of the member's annual plan maximum.

There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Bone Graft at time of implant placement

(1 per tooth position per 10 years: D6104)	\$350.00
Biopsy of oral tissue, hard or soft (tissue removal)	\$140.00

Alveoloplasty in conjunction with extractions,

per quadrant (1 per lifetime)	\$150.00
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Alveoloplasty not in conjunction with extractions,

per quadrant (1 per 5 years)	\$150.00
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Removal of odontogenic cyst or tumor
 \$195.00 |

Removal of exostosis or torus, per site
 \$200.00 |

Incision and drainage (intraoral, 1 per calendar year)

General anesthesia/IV sedation not covered

with this procedure
 \$125.00 |

Frenulectomy
 \$200.00 |

Excision of lesion (1 per calendar year)
 \$195.00 |

Bone replacement graft for ridge preservation

(1 per tooth per lifetime: D7953)
 \$250.00 |

ORTHODONTICS *This plan does not cover adult orthodontics; appliances must be in place before age 19. Provided for employees and unmarried dependent children enrolled in the plan. If a cosmetic upgrade (ex. invisalign® or clear brackets) is chosen and treatment is provided by a participating provider, the member may be responsible for a one time cosmetic upgrade fee, to be discussed prior to treatment.*

Limited/Interceptive/Appliance Therapy
 \$500.00 |

(Once per lifetime, prior to and not in the same month as comprehensive treatment. Additional appliances and office visits are the responsibility of the member.)

Comprehensive orthodontic treatment, appliance insertion

(Once per lifetime)
 \$950.00 |

Periodic orthodontic treatment visit
 \$135.00 |

(A benefit is provided for 24 completed active monthly treatment visits per life. Treatment visits beyond 24 months are the responsibility of the member, at the EBF allowance rate, when treatment is provided by a participating provider.)

Passive orthodontic treatment visit

(for cases started after 01/01/14)

(one treatment benefit per lifetime following comprehensive treatment, includes retainers)
 \$300.00 |

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation-each 15 minute increment with a maximum benefit of \$200.00

(per covered oral surgery visit)
 \$100.00 |

or

Intravenous sedation -each 15 minute increment

with a maximum benefit of \$200.00

(per covered oral surgery visit)
 \$100.00 |

Palliative (emergency) treatment of dental pain

(2 per calendar year)
 \$50.00 |

**DIAGNOSTIC SERVICES**

Consultation (1 per calendar year).....	\$100.00
Clinical Oral Evaluation (Examination)	
Evaluation – periodic, comprehensive, limited or detailed (3 per calendar year-outside annual maximum)	\$31.00
Dental Radiographs	
Intraoral complete series, including bitewings (1 per 3 years).....	\$70.00
or	
Panoramic (1 per 3 years)	\$70.00
<i>There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed within the same 12 month period as a complete series. Periapical x-rays are not covered within the same 12 month period as a panoramic image.</i>	
Periapical x-ray, each image (Maximum 10 per calendar year)	\$8.00
Bitewing x-ray, each image (Maximum 4 per calendar year).....	\$8.00
Occlusal image (2 per 3 years).....	\$21.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 yrs and over 3 per calendar year (outside annual maximum)	\$65.00
Dental prophylaxis, child-under age 12 (3 per calendar year).....	\$50.00
Fluoride, child-under age 19 (2 per calendar year).....	\$15.00
Sealants, child-under age 19, per tooth, covered on bicuspids and molars in the permanent dentition only (1 per 3 years).....	\$23.00
Space maintainers, child-under age 19 (1 per tooth per lifetime)	
Unilateral space maintainer	\$70.00
Bilateral space maintainer	\$140.00

RESTORATIVE (Fillings)

Amalgam Restorations (1 per each surface per tooth per 12 month period). <i>Includes tooth preparation, all adhesives, liners and bases and polishing to restore a tooth to proper form and function.</i>	
Permanent or Primary Teeth	
Amalgam, one surface	\$72.00
Amalgam, two surface	\$87.00
Amalgam, three surfaces	\$102.00
Amalgam, four or more surfaces	\$102.00
Resin-Based Composite Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials called resin-based composites.</i>	
Permanent or Primary teeth (Anterior or Posterior)	
Resin-based, one surface	\$80.00
Resin-based, two surfaces.....	\$92.00
Resin-based, three surfaces.....	\$110.00
Resin-based four or more surfaces, or involving incisal angle.....	\$110.00

RESTORATIVE (Crowns and Inlays/Onlays) *Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the plan. Any type of crown restoration that has been in place for 12 months is considered permanent and subject to the frequency limitation. Benefits are payable upon insertion of the crown or inlay/onlay.*

Pre-op radiographs are required for the review of this procedure.

*Crowns (1 per 5 years)	
Resin (permanent, anterior teeth only).....	\$147.00
Resin fused to metal	\$357.00
Porcelain/Ceramic	\$650.00
Porcelain fused to metal	\$650.00
3/4 cast metal.....	\$425.00

Full cast metal.....	\$545.00
*Implant/Abutment Supported Crowns (1 per 10 years)	
Implant/abutment supported, porc/ceramic	\$650.00
Implant/abutment supported, porc fused to metal.....	\$650.00
Implant/abutment supported, full cast metal.....	\$545.00
*Inlays/Onlays (1 per 5 years)	
Inlay/onlay, one surface	\$243.00
Inlay/onlay, two surfaces	\$293.00
Inlay/onlay, three or more surfaces.....	\$307.00
Other Restorative Services	
Recent crown, implant crown (1 per calendar year)	\$28.00
Stainless Steel crowns, deciduous teeth only (1 per tooth per 3 years).....	\$56.00
Pin retention - per tooth (1 per calendar year).....	\$20.00
Post and core, cast or prefabricated, per tooth (1 per 5 years).....	\$100.00

ENDODONTICS (Root Canal Therapy) (1 per tooth per lifetime)

<i>Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.</i>	
Root canal therapy, anterior	\$450.00
Root canal therapy, bicuspid.....	\$475.00
Root canal therapy, molar.....	\$565.00
Other Endodontic/Periradicular Services	
Pulpotomy, deciduous teeth only (1 per tooth per lifetime).....	\$55.00
Apicoectomy, 1st root (1 per tooth per lifetime).....	\$380.00
Apicoectomy, each additional root.....	\$120.00
<i>(General Anesthesia/IV sedation covered with Apicoectomy)</i>	
Retrograde filling, per root, in conjunction with apicoectomy (1 per tooth per lifetime)	\$100.00

PERIODONTICS *Gingivectomy, Osseous Surgery and Bone*

*Replacement Graft will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. **The treatment plan must be accompanied by x-rays and periodontal charting.** Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity. There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.*

Gingivectomy or gingivoplasty, per quadrant (1 per 5 years).....	\$300.00
Osseous surgery, per quadrant (1 per 5 years).....	\$525.00
Bone replacement graft, per tooth (D4263).....	\$250.00
Periodontal scaling and root planing, per quadrant (2 per calendar year) limited to 2 quadrants per visit.....	\$90.00
Periodontal maintenance procedure 3 per calendar year (outside annual maximum), either prophylaxis or periodontal maintenance procedure.....	\$65.00

PROSTHODONTICS (Removable) *A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next 5 or 10 year period. Benefits are payable only upon insertion of denture. Allowance includes post-delivery care, relines and adjustments for 6 months.*

**These services are limited to a six month waiting period for new subscribers and their eligible and enrolled dependents.*

*Complete Denture (1 per 5 years)	
Full upper or lower denture, permanent/immediate	\$650.00
Full upper or lower denture, interim.....	\$166.00
*Partial Denture (1 per 5 years)	
Partial upper or lower denture, permanent	\$650.00
Unilateral partial denture, permanent.....	\$300.00

Partial upper or lower denture, interim (anterior teeth only) ...	\$144.00
*Implant/Abutment Supported Dentures (1 per 10 years)	
Implant/abutment supported full upper or lower denture, permanent.....	\$650.00
Implant/abutment supported partial upper or lower denture, permanent.....	\$650.00
Repairs to Complete Dentures	
Replace missing or broken teeth (limited to 4 per calendar year)	\$50.00
Repairs to Partial Dentures	
Repair, replace or add clasp to existing partial.....	\$55.00
(limited to 4 per calendar year)	
Replace or add tooth to existing partial	\$50.00
(limited to 4 per calendar year)	
Rebase Complete Denture (1 per 2 years)	
Rebase-upper or lower	\$164.00
Reline of Dentures, Upper or Lower (1 per 2 years)	
Reline complete denture.....	\$150.00
Reline partial denture.....	\$150.00

PROSTHODONTICS (Fixed) Services are limited to permanent teeth replacement. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.

*These services are limited to a six month waiting period for new subscribers and their eligible and enrolled dependents.

*Pontics (1 per 5 years)	
Full cast metal.....	\$400.00
Porcelain fused to metal	\$500.00
Porcelain/Ceramic	\$500.00
Resin fused to metal.....	\$300.00
*Abutment Crowns For Fixed Bridge Retainers (1 per 5 years)	
3/4 Cast metal.....	\$425.00
Full cast metal.....	\$545.00
Porcelain fused to metal	\$650.00
Porcelain/Ceramic	\$650.00
Resin fused to metal.....	\$357.00
Retainer for Maryland-type bridge	\$230.00
*Implant/Abutment Supported Crowns for Fixed Bridge Retainers (1 per 10 years)	
Implant/abutment supported, cast metal.....	\$545.00
Implant/abutment supported, porc fused to metal.....	\$650.00
Implant/abutment supported, porcelain/ceramic.....	\$650.00
Other Fixed Partial Denture Services	
Recement Bridge, Implant Bridge (1 per calendar year)	\$40.00

ORAL SURGERY (Extractions) (1 per tooth per lifetime)	
Extract coronal remnants, primary tooth	\$80.00
Erupted tooth or exposed root	\$90.00
Surgical removal.....	\$125.00
Soft tissue impaction.....	\$225.00
Partial bony impaction.....	\$240.00
Full bony impaction	\$300.00
Surgical removal of residual roots.....	\$125.00
Other Oral Surgical Procedures	
Biopsy of oral tissue, hard or soft tissue removal.....	\$110.00
Alveoloplasty in conjunction with extractions, per quadrant (1 per lifetime).....	\$150.00
Alveoloplasty not in conjunction with extractions, per quadrant (1 per 5 years)	\$150.00
Removal of odontogenic cyst or tumor	\$200.00
Removal of exostosis or torus, per site.....	\$200.00
Incision and drainage (intraoral, 1 per calendar year)	
General anesthesia/IV sedation not covered with this procedure	\$125.00
Frenulectomy.....	\$200.00
Excision of lesion (1 per calendar year).....	\$200.00

There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.
Bone Graft at time of implant placement (1 per tooth position per 10 years: D6104).....\$350.00
Bone replacement graft for ridge preservation (1 per tooth per lifetime: D7953).....\$250.00

ORTHODONTICS This plan does not cover adult orthodontics; appliances must be in place before age 19. Provided for employees and unmarried dependent children enrolled in the plan. If a cosmetic upgrade (ex. invisalign® or clear brackets) is chosen and treatment is provided by a participating provider, the member may be responsible for a one time cosmetic upgrade fee, to be discussed prior to treatment.

*These services are limited to a 6 month waiting period for new subscribers and their dependents.

*Limited/Interceptive/Appliance Therapy	\$300.00
(Once per lifetime, prior to and not in the same month as comprehensive treatment. Additional appliances and office visits are the responsibility of the member.)	
*Comprehensive orthodontic treatment, appliance insertion (once per lifetime).....	\$650.00
*Periodic orthodontic treatment visit	\$80.00
(A benefit is provided for 24 completed active monthly treatment visits per life. Treatment visits beyond 24 months are the responsibility of the member, at the EBF allowance rate, when treatment is provided by a participating provider.)	
*Passive orthodontic treatment visit (for cases started after 01/01/14) (one treatment benefit per lifetime following comprehensive treatment, includes retainers).....	\$300.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation-each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit).....	\$100.00
or Intravenous sedation -each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit).....	\$100.00
Palliative (emergency) treatment (2 per calendar year).....	\$40.00

**DIAGNOSTIC SERVICES**

Consultation (1 per calendar year).....	\$100.00
Clinical Oral Evaluation (Examination)	
Evaluation – periodic, comprehensive, limited or detailed (3 per calendar year).....	\$32.00
Dental Radiographs	
Intraoral complete series, including bitewings (1 per 3 years).....	\$45.00
or	
Panoramic (1 per 3 years).....	\$45.00
<i>There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed within the same 12 month period as a complete series. Periapical x-rays are not covered within the same 12 month period as a panoramic image.</i>	
Periapical x-ray, each image (Maximum 10 per calendar year).....	\$6.00
Bitewing x-ray, each image (Maximum 4 per calendar year).....	\$8.00
Occlusal image (2 per 3 years).....	\$20.00

PREVENTIVE SERVICES

Prophylaxis, adult-12 and over (3 per calendar year).....	\$64.00
Prophylaxis, child-under age 12 (3 per calendar year).....	\$50.00
Fluoride, child-under age 19 (2 per calendar year).....	\$12.00
Sealants, child-under age 19, per tooth, covered on bicuspids and molars in the permanent dentition only (1 per 3 years).....	\$25.00
Space maintainers, child-under age 19 (1 tooth per lifetime)	
Unilateral space maintainer.....	\$97.00
Bilateral space maintainer.....	\$146.00

RESTORATIVE (Fillings)

Amalgam Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, all adhesives, liners and bases and polishing to restore a tooth to proper form and function.</i>	
Permanent or Primary Teeth	
Amalgam, one surface.....	\$60.00
Amalgam, two surfaces.....	\$80.00
Amalgam, three or more surfaces.....	\$96.00
Resin-Based Composite Restorations (1 per each surface per tooth per 12 month period) <i>Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials included in the group called resin-based composites.</i>	
Permanent or Primary Teeth (Anterior or Posterior)	
Resin based one surface.....	\$82.00
Resin based two surfaces.....	\$102.00
Resin based three surfaces.....	\$118.00
Resin based four or more surfaces or involving incisal angle.....	\$118.00

RESTORATIVE (Crowns and Inlays/Onlays) *Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the plan. Any type of crown restoration that has been in place for 12 months is considered permanent and subject to the frequency limitation. Benefits are payable upon insertion of the crown or inlay/onlay.*

Pre-op radiographs are required for the review of this procedure.

Crowns (1 per 5 years)	
Resin (permanent, anterior teeth only).....	\$200.00
Resin fused to metal.....	\$490.00
Porcelain/ceramic.....	\$535.00
Porcelain fused to metal.....	\$620.00
3/4 cast metal.....	\$280.00
Full cast metal.....	\$495.00

Implant/Abutment Supported Crowns (1 per 10 years)

Implant/abutment supported, porc/ceramic.....	\$535.00
Implant/abutment supported, porc fused to metal.....	\$620.00
Implant/abutment supported, full cast metal.....	\$495.00
Inlays/Onlays (1 per 5 years)	
Inlay/onlay, one surface.....	\$178.00
Inlay/onlay, two surfaces.....	\$208.00
Inlay/onlay, three or more surfaces.....	\$250.00

Other Restorative Services

Recent crown, implant crown (1 per calendar year).....	\$32.00
Stainless Steel crowns, deciduous teeth only (1 per tooth per 3 years).....	\$80.00
Pin retention, per tooth (1 per calendar year).....	\$20.00
Post and core, cast or prefabricated, per tooth (1 per 5 years).....	\$100.00

ENDODONTICS (Root Canal Therapy) (1 per tooth per lifetime)

Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.

Root canal therapy, anterior.....	\$435.00
Root canal therapy, bicuspid.....	\$475.00
Root canal therapy, molar.....	\$535.00

Other Endodontic/Periradicular Services

Pulpotomy, deciduous teeth only (1 per tooth per lifetime).....	\$31.00
Apicoectomy, 1st root (1 per tooth per lifetime).....	\$100.00
Apicoectomy, each additional root.....	\$100.00
<i>(General Anesthesia/IV Sedation covered with Apicoectomy)</i>	
Retrograde filling, per root, in conjunction with apicoectomy (1 per tooth per lifetime).....	\$50.00

PERIODONTICS *Gingivectomy, Osseous Surgery and Bone*

*Replacement Graft will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. **The treatment plan must be accompanied by x-rays and periodontal charting.** Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity. There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.*

Gingivectomy or gingivoplasty, per quadrant (1 per 5 years).....	\$250.00
Osseous surgery, per quadrant (1 per 5 years).....	\$350.00
Bone replacement graft, per tooth (D4263).....	\$250.00
Periodontal scaling and root planing, per quadrant (2 per calendar year, limited to 2 quadrants per visit).....	\$50.00
Periodontal maintenance procedure (3 per calendar year), either prophylaxis or periodontal maintenance procedure.....	\$64.00

PROSTHODONTICS (Removable) *A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next 5 or 10 year period. Benefits are payable only upon insertion of denture. Allowance includes post-delivery care, relines and adjustments for 6 months.*

Complete Denture (1 per 5 years)

Full upper or lower denture, permanent/immediate.....	\$600.00
Full upper or lower denture, interim.....	\$144.00
Partial Dentures (1 per 5 years)	
Partial upper or lower denture, permanent.....	\$600.00
Unilateral partial upper or lower denture, permanent.....	\$300.00
Interim partial denture, upper or lower (anterior teeth only).....	\$120.00
Implant/Abutment Supported Dentures (1 per 10 years)	

Implant/abutment supported full upper or lower denture, permanent	\$600.00
Implant/abutment supported partial upper or lower denture, permanent	\$600.00

Repairs to Complete Dentures

Replace missing or broken teeth (limited to 4 per calendar year) ..	\$50.00
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Repairs to Partial Dentures

Repair, replace or add clasp to existing partial (limited to 4 per calendar year)	\$50.00
Replace or add tooth to existing partial (limited to 4 per calendar year)	\$50.00

Rebase Complete Denture (1 per 2 years)

Rebase-upper or lower	\$235.00
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Reline of Dentures, Upper or Lower (1 per 2 years)

Reline complete denture	\$150.00
Reline partial denture	\$150.00

PROSTHODONTICS (Fixed) Services are limited to permanent teeth replacement. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.

Pontics (1 per 5 years)

Cast metal	\$275.00
Porcelain fused to metal	\$455.00
Porcelain/ceramic	\$455.00
Resin fused to metal	\$258.00

Abutment Crowns for Fixed Bridge Retainers (1 per 5 years)

3/4 cast metal	\$280.00
Full cast metal	\$495.00
Porcelain fused to metal	\$620.00
Porcelain/ceramic	\$535.00
Resin fused to metal	\$490.00
Retainer for Maryland-type bridge	\$220.00

Implant/Abutment Supported Crowns for Fixed Bridge Retainers

(1 per 10 years)

Implant/abutment supported, cast metal	\$495.00
Implant/abutment supported, porc fused to metal	\$620.00
Implant/abutment supported, porcelain/ceramic	\$535.00

Other Fixed Partial Denture Services

Recement bridge, implant bridge (1 per calendar year)	\$42.00
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ORAL SURGERY (Extractions) (1 per tooth per lifetime)

Extract coronal remnants, primary tooth	\$65.00
Erupted tooth or exposed root	\$95.00
Surgical removal	\$140.00
Soft tissue impaction	\$171.00
Partial bony impaction	\$245.00
Full bony impaction	\$355.00
Surgical removal of residual roots	\$140.00

Other Oral Surgical Procedures

Biopsy of oral tissue, hard or soft (tissue removal)	\$60.00
Alveoplasty in conjunction with extractions, per quadrant (1 per lifetime)	\$80.00
Alveoplasty not in conjunction with extractions, per quadrant (1 per 5 years)	\$80.00
Removal of odontogenic cyst or tumor	\$90.00
Removal of exostosis or torus, per site	\$200.00
Incision and drainage (intraoral, 1 per calendar year)	
General anesthesia/IV sedation not covered with this procedure	\$40.00
Frenulectomy	\$100.00
Excision of lesion (1 per calendar year)	\$90.00

There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Bone Graft at time of implant placement (1 per tooth position per 10 years: D6104)	\$350.00
Bone replacement graft for ridge preservation (1 per tooth per lifetime: D7953)	\$250.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation-each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit)	\$100.00
or Intravenous sedation -each 15 minute increment with a maximum benefit of \$200.00 (per covered oral surgery visit)	\$100.00
Palliative (emergency) treatment of dental pain (2 per calendar year)	\$45.00

HOURS OF OPERATION

PHONE NUMBER:
800-323-2732

BUSINESS HOURS:
**Monday through Friday
7:30 a.m. – 5 p.m.**

HELP US, HELP YOU

You must supply the following information when contacting our customer service help line:

- » Patient Name
- » Date of Birth
- » CSEA Employee Benefit Fund ID Number

AT YOUR ASSISTANCE

Customer service representatives are available from 7:30 a.m. to 5:00 p.m. Monday through Friday.

We are able to assist you with your questions regarding our dental plans, status of a claim/pre-treatment estimate and verification of eligibility.

WWW.CSEAEBF.COM**DENTAL PROVIDERS**

Please visit www.cseaebf.com to view the latest news, download forms, download plan summary descriptions, or learn how to become a participating dental provider.

PLAN MEMBERS

Plan members can order replacement ID cards, download forms or communicate with one of our specialized customer service representatives through our Live Chat feature. Live Chat is for member use only.

We are not in the position to provide the entire dental history for a patient. If you have specific teeth you are planning to treat, we are happy to provide you with that specific history.

The number of patient inquiries are limited to 5 per call.

Please note that eligibility changes frequently. We must process claims based on the eligibility for the actual date of service. If the eligibility changes (i.e. patient is no longer eligible for benefits, due to termination, lack of student proof) from when you verified information, the claim will be denied.

We do not provide our member information to outsourced agencies or third party call centers unless a signed Business Associate Agreement (BAA) is received. The BAA must be signed by both the dental office and the third party administrator and will be reviewed by CSEA EBF to ensure that it complies with HIPPA guidelines. A simple letter of authorization is not sufficient.

Please allow 2 to 4 weeks for claims and 4 to 6 weeks for predeterminations before checking on the status.



Reason for submission (Please one):

Statement of Actual Completed Services

Pretreatment Estimate/Predetermination

DENTAL CLAIM FORM

www.cseabf.com 800-323-2732

Claim Address: PO Box 489 Latham NY 12110-0489



SUBSCRIBER INFORMATION **PATIENT INFORMATION**

Subscriber's Name _____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy) _____

Male Female (Check one)

Subscriber's EBF ID Number _____

Street Address _____

City _____ State _____ Zip _____

Patient's Name _____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy) _____

Male Female (Check one)

Relationship to Subscriber (Check one)

Self Spouse Dependent Child Other

OTHER COVERAGE INFORMATION

Is other Dental coverage available? (Check one) Yes No

Name of Company _____

Other Dental Company Claim Address _____

City _____ State _____ Zip _____

Subscriber's Name _____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy) _____

Male Female (Check one)

Subscriber's ID Number _____

Plan/Group Number _____

Patient Relationship to Subscriber (Check one)

Self Spouse Dependent Child Other

RECORD OF SERVICES PROVIDED

Date of Service	Procedure Code	Tooth #/ Letter/Quad	Surface	Description of Service	Fee

Remarks: _____ **Total**

Missing Teeth (Mark each missing tooth with an X.)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	A	B	C	D	E
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	T	S	R	Q	P

SUBSCRIBER AUTHORIZATION **ADDITIONAL INFORMATION**

I hereby certify that the dated procedures have been completed.

X _____

Please issue payment directly to the dental entity below.

X _____

Radiographs enclosed? (Yes/No) _____

Is treatment for orthodontics? (Yes/No) _____

Date of insertion? (dd/mm/yyyy) _____

Replacement of prosthesis (Yes/No) _____

Date of prior placement? (dd/mm/yyyy) _____

BILLING DENTIST OR DENTAL ENTITY (NAME AND ADDRESS) **TREATING DENTIST**

NPI _____ License # _____ TIN or SSN _____

Phone Number _____

Treating Dentist Sign Below

X _____

Date (mm/dd/yyyy) _____

NPI _____ License # _____



CSEA EMPLOYEE BENEFIT FUND

DENTAL PROVIDER GUIDE

(800) 323-2732 | WWW.CSEAEBF.COM

JULY 2018
EMPLOYEE
BENEFIT
FUND.