compbenefits

Formerly American Dental Plan

The dental benefits company of choice!

2009 Dual Choice Dental Benefits

FOR

STATE OF FLORIDA EMPLOYEES

YOU HAVE A CHOICE OF TWO PLANS - SELECT ONE!

Prepaid/CompBenefits (Select 15)
People First Plan Code #4044

- The most cost effective way to receive dental care
- Each member may choose their own dentist from a list of participating general dentists
- Many "*no charge*" benefits available
- Save on all procedures
- No deductibles
- No maximum benefit limitations
- No waiting periods
- No Claim Forms
- Pre-existing conditions are covered

Includes:

- Adult & child orthodontia
- Cosmetic dentistry
- Out of area emergency benefit
- Vision, contact lens, and hearing aid programs

Indemnity/CompBenefits Insurance Co.
(Schedule B) People First Plan Code #4084

- Select any Dentist
- Claims are paid according to a stated Benefit Schedule
- $50 calendar year deductible (waived on Type I procedures)
- $1,000 calendar year maximum benefit
- No waiting periods

Includes:

- Coverage for: Type I (Preventive Care)
Type II (Basic Care)
Type III (Major Services)
- Vision, contact lens, and hearing aid programs

Good oral hygiene through regular dental care is imporant to total physical well being. However, dental care is expensive today and often neglected due to other financial priorities. Let CompBenefits make quality dental care affordable and budgetable for you through prepaid dental benefits.

Typical Preventive Care	Sample Charges	You Pay	Your Savings
Routine Office Visit	$47.00	$5.00	$42.00
Routine Oral Dental & Cancer Exams	$43.00	NO CHARGE	$43.00
Routine Cleanings	$53.00	NO CHARGE	$53.00
Fluoride (Children)	$20.00	NO CHARGE	$20.00
Complete Series of X-Rays	$80.00	NO CHARGE	$80.00

Notice that you can receive routine preventive care at NO CHARGE after a small copayment for the office visit. That is how CompBenefits makes preventive dentistry not only affordable, but budgetable too! **Plus, you will save 25-50% on all other dental procedures.**

CompBenefits is one of Florida's leading prepaid dental plan.

We service over 600,000 Floridians through the largest statewide network of participating general dentists and specialists, with over 2,000 from which you may choose. Our participating providers are all private practices licensed by the State of Florida and thoroughly credentialed by CompBenefits.

CompBenefits is as concerned as you are about the dental care available to you and your family. Our staff is comprised of clinically trained dental professionals including dentists, registered dental hygienists, and trained dental assistants who administer our quality management program.

It is this commitment to member satisfaction, along with our unique ability to provide the greatest access to quality, affordable dental care at such reasonable premiums, that has earned CompBenefits the membership of more of your fellow Floridians than any other prepaid dental plan.

Choice One

PREMIUM RATES FOR PREPAID PLAN:
PEOPLE FIRST BENEFIT PLAN CODE - PLAN #4044

(Select 15)	Monthly	Bi-weekly
Employee	$12.64	$ 6.32
Employee + Spouse	$21.20	$10.60
Employee + Child(ren)	$23.00	$11.50
Employee + Family	$32.98	$16.49

Choice Two

PREMIUM RATES FOR INDEMNITY PLAN:
PEOPLE FIRST BENEFIT PLAN CODE - PLAN #4084

(Schedule B)	Monthly	Bi-weekly
Employee	$14.74	$ 7.37
Employee + Spouse	$21.96	$10.98
Employee + Child(ren)	$23.30	$11.65
Employee + Family	$37.10	$18.55

DENTAL PLUS…

Preferred Vision Care Program

1-888-526-8000
www.preferredvisioncare.com

Highlights

- Wholesale cost for eyeglasses plus a dispensing fee
- Savings to 50% depending on the frames or lenses
- No limit on card usage
- The preferred provider is paid directly
- No pre-approval or claim forms are required
- Eye exams are not covered

Contact Replacement Program

1-866-337-2020*
www.truvision.com

Highlights

- Savings of up to 60% off retail cost
- National network of wholesale eyewear laboratories
- All contact lens manufacturers available
- Guaranteed first quality lenses
- Exact order lenses guarantee or purchase price refunded
- Lenses are shipped in sterile vials by UPS second day delivery
- Most orders are filled within 24 hours of receipt (excluding special orders)

*When calling, please refer to "Preferred Vision Care"

Hearing Aid Program Beltone Centers

1-800-BELTONE
www.beltone.com

Highlights

- No charge annual electronic hearing evaluations
- Free audiometric testing by a trained Beltone hearing aid specialist or audiologist
- 15% discount off the dispensor's regular list price on hearing aid products
- over 70 models and hundreds of customized Beltone hearing aids to choose from.

Please locate a Participating Preferred Vision Care Provider at www.preferredvisioncare.com

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People First Plan Code #4044

Schedule of Benefits and Subscriber Copayments

Choice One

Select 15

ADA CODE	PROCEDURE	PATIENT PAYS
APPOINTMENTS		
9430	Office visit (normal hours	$5.00
9440	Office visit after regularly scheduled hours	$35.00
9999	Emergency office visit during regularly scheduled hours, by report	$20.00
9999	Broken appointments (without 24 hr notice, per 15 min) Maximum $40 per broken appointment. No charge will be made due to emergencies.	$10.00
DIAGNOSTIC		
0120	Periodic oral evaluation	NO CHARGE
0140/0150/0160	Oral evaluation	NO CHARGE
0180	Comprehensive periodontal evaluation	NO CHARGE
0470	Diagnostic casts (study models)	NO CHARGE
0999	Diagnosis and treatment plan presentation, by report	NO CHARGE
9310	Consultation (second opinion) as provided by participating dentist	$10.00
0460	Pulp vitality tests	NO CHARGE
RADIOGRAPHS (X-rays)		
0210	Intraoral - complete series, including bitewings	NO CHARGE
0220	Intraoral - periapical - first film	NO CHARGE
0230	Intraoral - periapical - each additional film	NO CHARGE
0270	Bitewings - single film	NO CHARGE
0272	Bitewings - two films	NO CHARGE
0274	Bitewings - four films	NO CHARGE
0330	Panoramic	NO CHARGE
PREVENTIVE		
1110/1120	Prophylaxis (routine, once every 6 months)	NO CHARGE
1110/1120	Additional prophylaxis	$15.00
1201	Topical application of fluoride (including prophylaxis, up to 16 years of age)	NO CHARGE
1203	Topical application of fluoride (prophylaxis not included up to 16 years of age)	NO CHARGE
1351	Sealant - per tooth	$7.00
1330	Oral hygiene instruction	NO CHARGE
SPACE MAINTAINERS		
1510	Fixed, unilateral	$45.00 *
1515	Fixed, bilateral	$45.00 *
1520	Removable, unilateral	$85.00 *
1525	Removable, bilateral	$85.00 *
1550	Recementation of space maintainer	$10.00
RESTORATIVE (fillings)		
2999	Sedative base (under fillings), by report	NO CHARGE
Amalgam (Silver)		
2140	Amalgam - one surface, primary or permanent	NO CHARGE
2150	Amalgam - two surface, primary or permanent	NO CHARGE
2160	Amalgam - three surface, primary or permanent	NO CHARGE
2161	Amalgam - four or more surfaces, primary or permanent	NO CHARGE
Resin restoration (including acid etching, liners and bases)		
2330	Anterior one surface	$30.00
2331	Anterior two surfaces	$37.00
2332	Anterior three surfaces	$45.00
2510	Inlay - metallic - one surface	$85.00
2520	Inlay - metallic - two surfaces	$95.00
2530	Inlay - metallic - three or more surfaces	$120.00
2940	Sedative filling	$15.00
CROWN & BRIDGE		
2930	Prefabricated stainless steel - primary tooth	$45.00
2790/2791/2792/6790/6791/6792	Full cast crown	$220.00
2750/2751/2752/6750/6751/6752	Porcelain fused to metal crown	$240.00
2781	3/4 cast crown, predominantly base metal	$220.00
Pontics		
6210/6211/6212	Full cast pontic	$220.00
6240/6241/6242	Porcelain fused to metal pontic	$240.00
2950	Core build up, including any pins	$40.00
2951	Pin Retention - Per Tooth	$12.00
2952	Cast post and core	$90.00
2954	Prefabricated post and core	$75.00
2910/2920/6930	Recement inlay/onlay/crown/bridge (per unit)	$10.00
ENDODONTICS		
3220	Therapeutic pulpotomy	$30.00
Root Canals		
3310	Anterior	$100.00
3320	Bicuspid	$190.00
3330	Molar	$240.00
3410	Apicoectomy (anterior only)	$95.00
PERIODONTICS (gum treatment)		
4210	Gingivectomy/gingivoplasty - per quadrant	$120.00
4211	Gingivectomy/gingivoplasty - per tooth	$36.00
4341	Periodontal scaling and root planing - per quadrant	$45.00
4342	Scaling and root planing (one to three teeth per quadrant)	$45.00
4355	Full mouth debridement	$35.00
4381	Localized delivery of chemotherapeutic agents (2 teeth)	$45.00
4910	Periodontal maintenance procedures	$45.00
PROSTHODONTICS		
Standard complete dentures (includes adjustments within 30 days)		
5110	Complete maxillary (upper)	$260.00
5120	Complete mandibular (lower)	$260.00
5130	Immediate maxillary (upper)	$280.00
5140	Immediate mandibular (lower)	$280.00
Partial dentures (includes adjustments within 30 days)		
5211/5212	Maxillary/mandibular partial - resin base (with 2 clasps)	$280.00
5213/5214	Maxillary/mandibular partial - cast metal with resin base (with 2 clasps)	$350.00
5410/5411	Adjust complete - maxillary/mandibular	$15.00
5421/5422	Adjust partial denture - maxillary/mandibular	$15.00
5999	Additional clasps, by report	$30.00
REPAIRS TO PROSTHETICS		
5510/5610	Repair broken resin denture base	$15.00 *
5520/5640	Replace missing or broken teeth (each tooth)	$10.00 *
5520/5640	Each additional tooth	$10.00 *
5630	Repair or replace broken clasp	$15.00 *
5650	Add tooth to existing partial denture	$30.00 *
5850/5851	Tissue conditioning, maxillary/mandibular	$25.00
5730/5731/5740/5741	Relining (chairside)	$45.00
5750/5751/5760/5761	Relining (laboratory)	$35.00 *
EXTRACTIONS/ORAL SURGERY		
7111	Extraction, coronal remnants, primary tooth	NO CHARGE
7140	Extraction, erupted tooth or exposed root (evaluation and/or forceps removal)	NO CHARGE
7210	Surgical extraction of erupted tooth	$25.00
7220	Soft tissue impaction	$40.00
7230	Partially bony impaction	$60.00
7240	Completely bony impaction	$75.00
7250	Surgical removal of residual tooth roots	$25.00
7310	Alveoloplasty in conjunction with extractions - per quadrant	$20.00
7311	Alveoloplasty in conjuction with extractions (one to three teeth or tooth spaces, per quadrant)	$20.00
7320	Alveoloplasty not in conjunction with extractions - per quadrant	$50.00
7321	Alveoloplasty not in conjunction with extractions (one to three teeth or tooth spaces, per quadrant)	$50.00
ANESTHESIA		
9215	Local anesthesia	NO CHARGE
9230	Analgesia (nitrous oxide - per 15 minutes)	$15.00
ADJUNCTIVE SERVICES		
9951	Occlusal adjustment - limited	$25.00
9952	Occlusal adjustment - complete	$150.00

ORTHODONTICS

Benefits for orthodontics for adults and children are available from Participating Orthodontists at their usual fee less 25%.

THE ABOVE COPAYMENTS DO NOT INCLUDE THE ADDITIONAL COST OF PRECIOUS AND SEMI-PRECIOUS METAL.

All procedures listed might not be performed by the Participating General Dentist you select. The copayments shown apply to those Company Participating General Dentists who do perform those services. Therefore, you are encouraged to discuss availability of the scheduled services with your Participating General Dentist. Procedures not listed on the schedule of benefits, that are performed by the Participating General Dentist, will be charged at that Participating General Dentist's usual and customary fee less 25%.

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Choice One

SPECIALISTS:

Should you need a specialist (i.e., Endodontist, Orthodontist, Oral Surgeon, Periodontist, Prosthodontist, Pediatric Dentist), you may be referred by your Participating General Dentist, or you may refer yourself to any Participating Specialist from our directory. Upon identification of yourself as a Company member, you will receive a 25% reduction from usual and customary fees for services performed by the Participating Specialist. Specialist services from a Participating Specialist are available only in areas where the dental plan has a Participating Specialist. In those areas where a Participating Specialist is not available, you may be referred to another Participating General Dentist or, if medically necessary, to an out-of-network specialist.

Note: When crown and/or bridgework exceeds six consecutive units, the patient may be charged an additional $25.00 per unit.

* Plus laboratory fees when applicable.

Limitations and Exclusions

1. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as provided in Section VIII, Paragraph C of the Certificate.
2. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.
3. Company does not provide coverage for the following services:

   a) Cost of hospitalization and pharmaceuticals, drugs or medications.

   b) Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.

   c) Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.

   d) Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the Member.

   e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.

   f) Services for injuries and conditions which are paid or payable under Workers' Compensation or Employers' Liability laws.

   g) Treatment for cysts, neoplasms and malignancies.

   h) General anesthesia.

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People First Plan Code #4084
CompBenefits Insurance Company

Choice Two

Schedule B

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

TYPE I - PREVENTIVE DENTAL SERVICES

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

TYPE II - BASIC DENTAL SERVICES

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

TYPE II - BASIC DENTAL SERVICES (CONT.)

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

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TYPE II - BASIC DENTAL SERVICES (CONT.)

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

TYPE III - MAJOR DENTAL SERVICES

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

TYPE III - MAJOR DENTAL SERVICES (CONT.)

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

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

MAJOR RESTORATIVE LIMITATIONS

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

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

EXCLUSIONS

Benefits will not be paid for:

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

PREDETERMINATION

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

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

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For participating dentist information, please visit our website at:

www.compbenefits.com/custom/adpstateemployees/

Or contact our Customer Care Department at:

(866) 879-3630

Once you have enrolled in the Select 15 Choice One - Prepaid Plan, People First Plan Code #4044 please visit www.mycompbenefits.com to register and select a primary care dentist.

How to Register Online: It's fast and simple!

Step #1: Go to *www.mycompbenefits.com.*

Step #2: Select Click here to Register Now!

Step #3: Type the requested information on the PIN Registration page and click Next.

Step #4: In the next page, enter your Member ID number.

Step #5: Enter your demographic information as it appears on your enrollment form or as indicated on your ID card. Click Submit.

Member Access to Online Services
24 Hours a Day, 7 Days a Week

Please contact us when you move, change employment, or change telephone numbers.

It will help us to serve you better.

CompBenefits

Customer Care Number - 866-879-3630

www.compbenefits.com/custom/adpstateemployees/

This brochure contains a brief description of the plan benefits by CompBenefits and CompBenefits Insurance Company.
A more complete explanation of benefits may be obtained by contacting CompBenefits or your local representative.