

OHIO AFSCME CARE PLAN



DENTAL BENEFITS LEVEL 2-A

**Effective:
March 1, 2003**

OHIO AFSCME CARE PLAN

To All Eligible Participants:

The Ohio AFSCME Care Plan is administered by a Board of Trustees comprised of seven Union representatives and seven Employer representatives. The Ohio AFSCME Care Plan receives contributions from your employers pursuant to the provisions of the collective bargaining agreement between your Union and your Employer. The Board of Trustees uses those contributions to provide a benefit plan.

This booklet describes your dental benefits. The benefit is provided directly from the Care Plan. Your life insurance, vision, prescription drug, and hearing aid benefits are described in other booklets which will be provided to you if you are eligible to receive those benefits, and your Employer and your Union have negotiated for the provision of these benefits from the Care Plan. The rules regarding eligibility for the dental benefit, a description of the benefit, and amounts payable for the benefit are set forth in this booklet. You must follow the provisions of the Plan for dental benefits to be paid. In all cases which are not emergency in nature, and in which will be proposed course of treatment will cost more than \$500, your dentist must obtain a pre-determination of benefits, by submitting the Examination and Treatment Record and periodontal charting describing each procedure necessary to fully complete treatment of the case. In all cases where pre-determination is necessary, that is in all cases over \$500, x-rays or study models must be submitted with the Examination and Treatment Record.

In all cases over \$500, where necessary pre-determination of benefits is not obtained, the maximum fee paid by the dental benefit program may be limited to 80% of the amounts shown in the Table of Allowances for Dental Procedures.

Please carefully read the information in this booklet and the other booklets so that you will become familiar with all the benefits provided to you and your eligible dependents under the Plan.

Sincerely,

BOARD OF TRUSTEES

John A. Lyall, Chair
Mark E. Owens, Secretary
Deborah Allison, Trustee
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OHIO AFSCME CARE PLAN

1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420

Michael D. Bauer, Plan Administrator

COBRA CONTINUATION COVERAGE “Very Important Notice”

Introduction

You are getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Benefit booklet or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally does not accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child"

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (Under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your applicable Plan office:

CLEVELAND

1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420
(800) 526-7201

TOLEDO

420 South Reynolds Rd.
Suite 106
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631

CINCINNATI

1213 Tennessee Avenue
Cincinnati, Ohio 45229
(513) 641-4111
(800) 562-1822

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), employee's divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until **36 months** after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this **18-month** period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of **29 months**. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the Plan of your disability within the initial 18-month period of the continuation coverage or if later, within sixty (60) days after SSA issues the disability determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the

spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. You must provide this notice to your applicable Plan office:

CLEVELAND

1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420
(800) 526-7201

CINCINNATI

1213 Tennessee Avenue
Cincinnati, Ohio 45229
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TOLEDO

420 South Reynolds Rd.
Suite 106
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Trade Act of 2002

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, then you will be provided with an additional 60-day enrollment period, with continuation coverage beginning on the date of such TAA approval.

If You Have Questions

Questions regarding your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health Plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at <http://www.dol.gov/ebsa>. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

If you have changed marital status, or you, your spouse, or dependents have changed addresses, please notify the plan administrator at Ohio AFSCME Care Plan at one of the following addresses:

CLEVELAND

1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420
(800) 526-7201

CINCINNATI

1213 Tennessee Avenue
Cincinnati, Ohio 45229
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Suite 106
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631

USERRA CONTINUATION COVERAGE

If you are called into military service (active duty or inactive duty training) or certain types of service in the National Disaster Medical System, you may elect to continue your health coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are called into military service for up to 31 days, your group health care coverage will continue if you make the required employee contributions, if applicable. If you are called into military service for more than 31 days, you and your eligible dependents may continue coverage by paying the required monthly premiums for up to 24 months under USERRA.

Your coverage will continue until the earlier of:

- The date you or your dependents do not make the required premium payment;
- The date you become eligible for coverage under the Ohio AFSCME Care Plan;

- The end of the period during which you are eligible to apply for re-employment in accordance with USERRA;
- The last day of the month after 24 consecutive months; or
- The date the Ohio AFSCME Care Plan terminates.

You need to notify the Plan Administrator at one of the Local offices at least 30 days prior to the date you will leave for the military. For more information about the election of USERRA coverage and payment of the required premiums, contact one of the following:

CLEVELAND

1603 East 27th Street
 Cleveland, Ohio 44114
 (216) 781-6420
 (800) 526-7201

CINCINNATI

1213 Tennessee Avenue
 Cincinnati, Ohio 45229
 (513)641-4111
 (800) 562-1822

TOLEDO

420 South Reynolds Rd.
 Suite 106
 Toledo, Ohio 43615
 (419) 536-0880
 (800) 237-2631

If you do not elect to continue coverage under USERRA, your coverage will end immediately when you enter military service. Your eligible dependents may continue coverage under the Ohio AFSCME Care Plan by electing and making self-payments for COBRA Continuation Coverage.

Upon your discharge from military service, you may apply for reemployment with an employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any health insurance coverage offered under the Ohio AFSCME Care Plan. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service and your honorable discharge from that service.

The following information outlines the deadlines that apply to your rights to reemployment and reinstatement of health care coverage. When you are discharged or released from military service that lasted:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for an employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for an employer;

- More than 180 days, you have up to 90 days after discharge to return to work for an employer.

When you are discharged, if you are hospitalized or recovering from an illness or injury that was incurred during the military service, you have until the end of the period that is necessary for you to recover to return to work for an employer.

If you take military leave but do not elect USERRA coverage within sixty days of the receipt of the notice of your right to elect the coverage, your health insurance coverage offered under the Ohio AFSCME Care Plan will terminate. When you meet the re-employment deadlines and return to work with an employer, your health insurance coverage will be reinstated upon your re-employment date without regard to any waiting periods or pre-existing condition limitations.

I. ELIGIBILITY

A. Employee

- 1. Effective Date of Your Benefit Coverage.** You are eligible to receive benefits as a Participant of the Ohio AFSCME Care Plan on the first day of the month on which your employer is first required to make a monthly contribution to the Plan on your behalf in accordance with the provisions of either your collective bargaining agreement or participation agreement.
- 2. Termination Date of Your Benefit Coverage.** You will no longer be eligible to receive benefits as of the last day of the month for which your employer is last required to make a contribution to the Plan on your behalf in accordance with the provisions of either your collective bargaining agreement or participation agreement.
- 3. Exceptions to the Termination of Your Benefit Coverage.**
 - a. Approved Leave of Absence.** If your benefit coverage terminates because of approved leave of absence, your benefit coverage may be continued during the period of approved leave of absence but not for longer than twelve (12) months, provided you pay the required contributions to the Plan in advance for each month for which your benefit coverage is to be continued beginning with the first month following the termination of your eligibility for benefit coverage.
 - b. Disability.** If your benefit coverage terminates because of disability, your eligibility for benefit coverage will be extended for three (3) months subject to submission of any information required by the Plan to verify your disability. At the end of three (3) months, benefit coverage may be continued during the period of your disability but not for longer than nine (9) months provided you pay the required contributions to the Plan for each month following the termination of your eligibility for benefit coverage.
 - c. Cobra Continuation Coverage.** See the Cobra Continuation Coverage "Very Important Notice" for a summary of your rights and obligations to continue coverage for a limited time period through self-payment to the Plan.

4. Waiver of Coverage. You have the right to elect to not receive coverage under this Plan by notifying the Plan Administrator in writing.

B. Benefit Plan Coverage For Your Dependents

1. Definition of Dependent. Dependent means only (1) your spouse, or (2) your child, including a legally adopted child or any stepchild who is less than twenty-eight (28) years of age. The term "dependent" will not include any person who is in full-time military, naval or air service status.

2. Dependents' Eligibility Date. You become eligible for coverage for your dependents on the later of (1) your eligibility date for benefit coverage, or (2) the date you acquire your first dependent.

3. Dependents' Effective Date. The benefit coverage for each eligible dependent will become effective on the date he or she qualifies as a dependent.

4. Termination of Dependents' Benefit Coverage. Your dependents' benefit coverage will automatically terminate on the earlier of (a) the date your benefit coverage terminates, or (b) the date he or she ceases to qualify as a dependent.

5. Exceptions to the Termination of Your Dependents' Benefit Coverage.

- a.** Dependent children are eligible to participate in the Plan up to age 28. The benefit coverage of a dependent child will not cease solely because the child has passed the upper age limit for dependent children as long as the child is not capable of self-support because of mental or physical disability and:
1. the disability began before the upper age limit was reached under the Plan and the dependent disabled child was an eligible dependent under the Plan when he/she reached the upper age limit; and
 2. is unmarried and depends on the Employee for financial support.

The Plan may require periodic proof of mental or physical disability. If not provided earlier, written notice of mental or physical disability must be provided to the Plan office within 31 days of when the dependent child attains age 28. This extension will continue until the earliest of (1) the date he or she ceases to be eligible for reasons other than age, (2) the date he or she ceases to be incapacitated, or (3) the thirty-first (31st) day after we request additional proof of his or her incapacity if you fail to furnish such proof.

- b. COBRA Continuation Coverage.** See the COBRA Continuation Coverage "Very Important Notice" for a summary of your rights and obligations to continue coverage for a limited time period through self-payment to the Plan.

6. Waiver of Coverage. You have the right to elect to not receive coverage for your Dependents under this Plan by notifying the Plan Administrator in writing.

II. SUMMARY OF DENTAL BENEFITS

For You and Your Dependents

Dental Expense Benefit. The Plan will help pay for necessary dental expenses incurred by you and your dependents while covered under this dental Plan. The benefits are described below and payment will be limited to the lesser of either the Usual, Customary and Reasonable percentages specified for the dental procedures, or the specified percentages for the dental procedure multiplied by the fee actually charged by the dentist for the dental procedure shown in the Table of Allowances for Dental Procedures. Dental Expense is deemed to be incurred on the date on which the service or supply which gives rise to the expense is rendered or obtained.

III. COVERED DENTAL EXPENSE

The term “**Covered Dental Expense**” means only expense incurred for treatment received from a Dentist which, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. The percentage payable for a Covered Dental Expense will not exceed the percentage specified in the Table of Allowances for Dental Procedures for the procedures reported on any one Attending Dentist’s Statement. If the dental procedure performed is not listed in the Table, we will determine the applicable amount for such procedure on the basis of a dental procedure of equivalent gravity and severity listed in the Table.

Orthodontic Benefit for Eligible Dependent Children Under Age 19.

Orthodontic benefits shall be provided only to eligible dependent children under age 19 as follows:

1. Covered Orthodontics are defined as the procedures performed by a licensed dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their function.
2. All payments shall be on a periodic basis.
3. The Plan will pay 50% of the lesser of the usual, customary and reasonable fee or the fee actually charged by a dentist for Orthodontics.
4. The maximum lifetime amount payable for Orthodontic services rendered to an eligible patient shall be \$1,500.00, and the limitations on maximum amounts payable during a calendar year for other Covered Dental Expenses shall not apply to Orthodontics.
5. **Application of \$500 Increase in Maximum Life-time Amount.**
The plan will pay a pro-rata share of the \$500 increase in the maximum lifetime amount for an Orthodontic treatment plan prior to March 1, 1997. The pro-rata share of the \$500 increase will be determined by dividing the number of full months remaining in the Orthodontic treatment plan after

March 1, 1997 by the number of full months involved in the Orthodontic treatment plan. The resulting percentage would then be multiplied times \$500 to equal an additional payment amount. However, any additional payment amount will be limited so that the plan does not pay more than 50% of the lesser of the usual, customary and reasonable fee or the fee actually charged by a dentist for Orthodontics for the time period remaining in the treatment plan after March 1, 1997.

6. **Exclusions and Limitations.** In addition to the Dental Limitations stated in this section, the following exclusions shall apply to Orthodontic services.
- a. The obligation of the Plan to make monthly or other periodic payments for an Orthodontic treatment Plan begun prior to the eligibility date of the patient shall commence with the first payment due following the eligible dependent's eligibility date. The above mentioned maximum amount payable will apply fully to this and subsequent payments.
 - b. The obligation of the Plan to make monthly or other periodic payments for Orthodontic Services shall terminate on the payment due date next following the date the dependent child loses eligibility, or the employee loses eligibility, or upon termination of treatment for any reason prior to completion of the case, or upon the termination date of participation in the Plan by your employer, whichever shall occur first.
 - c. The Plan will not make any payment for repair or replacement of an Orthodontic appliance furnished, in whole or part, under this Plan.

Pre-Determination Requirement. In all cases which are not emergency in nature, and in which the proposed treatment will cost more than \$500, your Dentist must obtain a pre-determination of benefits, by submitting the Examination and Treatment Record and periodontal charting fully completed to describe each procedure necessary to fully complete treatment of the case. In all cases where pre-determination is necessary, that is in all cases over \$500, x-rays or study models and perio charts if applicable must be submitted with the Examination and Treatment Record.

In all cases over \$500, where necessary pre-determination of benefits is not obtained, the maximum fee paid by the dental benefits program may be limited to 80% of the amounts which would otherwise be payable to the Plan.

Extension of Dental Expense Benefit. If within one (1) month after you cease to be eligible for this Dental Expense Benefit, Covered Dental Expense is incurred for services or supplies furnished in connection with a dental procedure which began prior to the date the benefit coverage ceased, benefits will be payable for such expense provided the Dental Benefit is still in force under the Plan on the date the expense is incurred. However, x-rays

and prophylaxis treatment will not be considered as the beginning of a dental procedure.

SUMMARY OF MATERIAL MODIFICATIONS

Effective July 1, 2016 for

Dental Benefit Plan Level 2-A

Effective July 1, 2016, Dental Benefit Plan Level 2-A is amended by the addition of the following Implant Benefit provisions in the Section III Covered Dental Expense and the addition of the following Maximum Allowances to the Table of Allowances for Dental Procedures:

Implant Benefit.

Implants and implant related services when in the opinion of the Plan dental consultant the services are clinically necessary.

1. The Plan will pay up to the total amount shown in the Table of Allowances for Dental Procedures for the condition being treated, but no more than the Usual, Customary, and Reasonable charges for the dental procedure or the fee actually charged by the Dentist for the dental procedure shown in the Table of Allowances for Dental Procedures.
2. The maximum lifetime amount payable for the Implant Services and Implant Related Services rendered to an eligible patient shall be \$1500.00.
3. Exclusion and Limitations: In addition to the Dental Limitations specified in this section, the following exclusions and limitations apply to Implant Services and Implant Related Services:
 - a. Implants placed for temporary anchorage during orthodontic treatment are covered only under the Orthodontic Benefit, (if any), and subject to Orthodontic Benefit limitations and exclusions.
 - b. Payments for implant and non-implant related services will not exceed the Plan annual maximum.
 - c. Removable implant stabilized prostheses will be covered as an alternate benefit for the most similar conventional removable appliance subject to limitations and exclusions for conventional removable appliances and the Plan annual maximum.
 - d. Implants, implant supported abutments, implant supported pontics, routine implant services, adjunctive services primarily for implants, fixed full implant supported dentures, and fixed partial implant

supported dentures, are covered under the terms and conditions for the implant benefit only. Hybrid dentures are considered as fixed dentures for Dental Expense Benefit purposes.

- e. Individual implant borne crowns are covered as implant supported crowns until the lifetime implant benefit is exhausted. Charges will accrue first to the implant benefit and then paid up to the annual maximum for an alternate benefit as pontics. If more than one-half the crown benefit can be paid under the implant benefit, the Plan will complete payment for an implant-supported crown under the annual maximum benefit. If less than half of the implant-supported crown can be paid under the implant benefit, the entire crown will be paid as an alternate benefit subject to the annual maximum.
- f. Routine preventive services for implants and removal of implants will be covered as an alternate benefit under the annual maximum. For example, prophylaxis, including natural teeth and implants, will be considered to be one (1) prophylaxis.
- g. Alternate benefit for prophylaxis will be applied if performed on a separate date from prophylaxis for remaining natural teeth. If prophylaxis/periodontal maintenance is performed on same date as implant maintenance, the implant maintenance will be considered to be a part of the prophylaxis. Frequency limit is once per calendar year.
- h. Provisional pontics are excluded unless treatment such as periodontal surgery delays final crown by more than 3 months.

DENTAL LEVEL II-A

Dental Limitations and Exclusions.

This Plan **DOES NOT PAY** expenses for:

- More than two oral examinations during any calendar year; or
- Dental procedures for cosmetic reasons; or
- More than two prophylaxis treatments during any calendar year; or
- Orthodontic, Including surgical procedures performed for orthodontic purposes except as specifically allowed for dependent children under the age of 19.
- Replacement of an existing prosthesis which is or can be made satisfactory; or
- Replacement of a lost or stolen appliance; or
- Replacement of a prosthesis or lab-processed restoration, except a crown necessary for restorative purposes only, for which benefits were paid under this Plan if the replacement occurs within five (5) years from the date the expense was incurred, unless (a) the replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural

teeth, (b) the prosthesis is a stayplate or similar temporary partial prosthesis, and within four months is being replaced by a permanent prosthesis, or (c) the prosthesis, while in the mouth, has been damaged beyond repair as a result of injury while eligible for coverage; or

- Any procedure which began before the date you eligible for coverage, or any supplies furnished in connection with such procedure, except x-rays and prophylaxis treatment will not be considered as the beginning of a dental procedure; or
- More than \$4,000.00 for treatment incurred during any calendar year for you and for each dependent; or
- Any injury or sickness covered by any workers' compensation or occupational disease law; or
- Any injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain; or
- More than \$2,000 lifetime for periodontal surgical services for you or for each dependent; or
- Procedures used primarily to alter vertical dimension; or
- With the exception of nightguards, services for the treatment of temporomandibular joint (TMJ) disorders, cranio-facial pain disorders and orthognathic surgery; or
- Services covered under the participant's medical Plan; or
- Placement of bone grafts or extraoral substances in the treatment of periodontal disorders or for ridge augmentation; or
- Charges for ridge augmentation or implant procedures in excess of \$1500 lifetime; or
- Treatment for congenital malformations except dental care which would otherwise be covered (e.g., replacement of a congenitally missing tooth); or
- Charges for procedures which are experimental in nature, or not generally recognized by the dental profession as the usual and customary services for the condition being treated; or
- Customization of dental prosthesis, Including personalized, elaborate, or precision attachment dentures or bridges, or specialized techniques unless the prosthesis cannot be made to function without the specialized technique; or
- Fixed prostheses on periodontally compromised teeth with significant bone loss, unless it is certified by an independent periodontist that needed therapy is complete and that the prognosis for the affected tooth (teeth) is good; or
- Fixed prostheses on endodontically compromised teeth, unless it is certified by an independent endodontist that needed therapy is complete and that the prognosis is good; or

- All malignant lesions and non-malignant lesions greater than 2.5 cm, unless specifically covered by the Dental Schedule of Benefits; or
- Any procedure not listed in the Table of Allowances for Dental Procedures.

When multiple procedures are performed on the same operative site, the benefit is limited to the most comprehensive inclusive service. Related services will be pro-rated for non-redundant parts of those services.

IV. DEFINITIONS

“Calendar Year” means the period of twelve (12) consecutive months beginning with the first day of each January.

“Expense Incurred” means only fees and prices regularly and customarily charged for dental care generally furnished in the particular geographical area concerned. Expense is considered to be incurred on the date the service or supply is rendered or obtained.

“Dentist” means only the person licensed to practice as a Dentist, Doctor of Medicine or Doctor of Osteopathy.

“Hospital” means an institution which (1) has permanent, full-time facilities for bed care of five (5) or more resident patients, (2) has a doctor in regular attendance, (3) provides twenty-four (24) hours a day service by Registered Nurse, (4) primarily provides diagnostic and therapeutic facilities for the medical and surgical care of patients, and (5) is not a rest home, nursing home, convalescent home, or a place for the aged or drug addicts. The term “Hospital” will also include a community mental health facility or alcoholic treatment facility certified by the appropriate regulatory agency of the State of Ohio or approved by the Joint Committee on Accreditation of Hospitals.

“CT/TPS – Chairtime/Type of Provider and Severity” the amount payable for the procedures is determined based on review by the Care Plan’s dental consultant of the chairtime, type of provider and severity using a schedule prepared by the Care Plan’s dental consultant.

“CT/L – Chairtime/Laboratory” the amount payable for the procedures is determined based on review by the Care Plan’s dental consultant of the chairtime and laboratory using a schedule prepared by the Care Plan’s dental consultant.

“CT/S – Chairtime/Severity” the amount payable for the procedures is determined based on review by the Care Plan’s dental consultant of the chairtime and severity using a schedule prepared by the Care Plan’s dental consultant.

“CT -- Chairtime” the amount payable for the procedures is determined based on review by the Care Plan’s dental consultant of the chairtime using a schedule prepared by the Care Plan’s dental consultant.

V. COORDINATION OF BENEFITS

Payment of Dental Benefits under the Plan is subject to Coordination of Benefits.

“Coordination of Benefits” means that if you or your eligible dependents are covered under more than one Plan, the total amount payable under This

Plan, when added to the amount or value of the benefits or services provided by all Other Plans, will not exceed the amount of the Allowed Expense which is incurred. In no event will the amount paid by us be more than would be paid if there were no Other Plan. Coordination of Benefits provisions will be applied on a calendar year basis.

The term **“Other Plan”** means any other coverage for dental benefits under: (a) an insurance policy, a service Plan contract, a pre-payment Plan or other non-insured Plan, or (b) Medicare.

Other Plan does not include: (a) an accidental injury policy provided through a school for students through grade twelve (12), (b) a hospital indemnity Plan except as allowed by law, (c) the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS), nor (d) an individual policy except one which provides “no-fault” automobile insurance or is issued on a franchise basis. “No-fault” automobile insurance means coverage under which personal injury benefits are paid as expenses accrue without regard to fault.

The term **“Allowed Expense”** means the charge for dental care which is customary, needed and reasonable and for which the claimant is entitled to payment under one or more Plans. When any Other Plan provides services rather than cash payment, the reasonable cash value of each service will be an Allowed Expense.

Effective March 1, 1989 for all dental care incurred on or after March 1, 1989, if a person is covered under This Plan and under one or more Other Plans, the following rules will apply. In these rules, the Plan which pays first does so without regard to coverage under Other Plans.

1. A Plan which does not provide for Coordination of Benefits will pay its benefits first.
2. A Plan which covers a person other than as a dependent will pay its benefits before the Plan which covers the person as a dependent.
3. When a child is covered by the Plans of both parents, unless they are divorced or legally separated, the Plan of the parent whose birthday occurs earlier in the Calendar Year, regardless of the year of birth, will pay first. However, if the Other Plan’s Coordination of Benefits provisions do not use the parents’ birthdays to determine which of the parents’ Plans pays first, the Other Plan’s provisions will make the determination.
4. If a child’s parents are divorced or legally separated, payment will be made: (a) under the Plan of the parent with custody before the Plan of the stepparent or of the parent without custody, or (b) under the Plan of a stepparent before the Plan of the parent without custody. However, if, by court decree, one parent is held responsible for the child’s health care expenses, payment will be made first under the Plan of that parent.
5. When the rules above do not apply, the Plan which has covered the person for the longer period of time will pay its benefits first. A new Plan is not established when coverage by one carrier is replaced within one day of that another.

With the consent of the covered person, we may release to or obtain from the Other Plan any data needed to carry out these provisions or those of Other Plans.

We have the right to recover from Other Plans or persons any payments made which exceed those required by these provisions. We also have the right to make direct payment to Other Plans or persons of amounts paid by them which should have been paid by us. Such payment will be deemed benefits paid under This Plan and will discharge our liability to the extent of the payment.

VI. BENEFIT CLAIM PROCEDURE

In order to receive payment of your dental benefit, a claim form must be submitted to:

CLEVELAND

1603 East 27th Street
Cleveland, OH 44114
(216) 781-6420
(800) 526-7201

CINCINNATI

1213 Tennessee Avenue
Cincinnati, Ohio 45229
(513) 641-4111
(800) 562-1822

TOLEDO

420 South Reynolds Rd.
Suite 106
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631

Amounts payable for claims will be paid to the claimant upon receipt by the Care Plan office of due written proof of Dental Expense incurred. Once the covered person has authorized it, in an application or otherwise, we may pay Dental Expense benefits directly to the person rendering dental services, unless we are previously notified to the contrary, and in writing, by the covered person.

The Care Plan reserves the right to have the covered person examined by a dentist of the Care Plan's choice prior to certifying the pre-determination of benefits, and if, in the opinion of the dentist chosen by the Care Plan, such dental services are not appropriate under the circumstances, benefits payable must be reduced to amounts determined as appropriate.

We will pay the Dental Expense benefits to you. If any benefits are payable after your death, we may pay the benefit to any person related to you whom we deem is entitled to the payment; we will then be discharged to the extent of payment.

All benefit claims must be submitted by December 31 after the end of the calendar year in which the expense for the dental benefit was paid. For example, all benefit claims for 2013 must be submitted to the proper Plan office by December 31, 2014.

VII. GENERAL INFORMATION

No legal action on claims will be taken within sixty (60) days after a benefit claim is submitted as required by the benefit Plan nor later than three (3) years after the benefit claim is required to be submitted to the Plan office.

The Plan does not replace nor affect any requirement for coverage by workers' compensation insurance.

Any provision of the benefit Plan which is in conflict with the laws of the governing jurisdiction is hereby amended to conform to the minimum requirements of such law.

VIII. INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The Ohio AFSCME Care Plan (The Plan) is administered by a joint Board of Trustees, consisting of fourteen (14) Trustees, seven (7) appointed by the Employers participating in the Plan, and seven (7) appointed by the Union. The Board of Trustees has been designated as the agent for the service of legal process.

The joint Board of Trustees is responsible for the operation and administration of the Plan. As of December 1, 2017, the members of the Board of Trustees are:

Employer Trustees

Ms. Deborah Allison
City of Cincinnati
805 Central Avenue
Suite 100, Centennial Two
Cincinnati, Ohio 45202

Mr. Mark E. Owens
Clerk of Dayton Municipal Court
301 West 3rd Street
Dayton, Ohio 45402

Mr. Michael Stern
Senior VP and Chief of Staff
The MetroHealth System
2500 MetroHealth Drive
Cleveland, Ohio 44109-1998

Mr. Richard Jackson
Director, Human Resources
Trumbull County
160 High Street, Fifth Floor
Warren, Ohio 44481

Ms. Joni Harbaugh
Benefits Manager
Cuyahoga County
2079 East 9th Street
Cleveland, Ohio 44115

Mr. Michael Phillips
Senior Vice President, Chief Legal Officer
The Metro Health System
2500 Metro Health Drive
Cleveland, Ohio 44109

Mr. Thomas J. Ritchie Sr.
Dayton Civil Service Board Member
1644 Spaulding Rd.
Dayton, Ohio 45342

Union Trustees

Mr. John A. Lyall
President
AFSCME Ohio Council 8, AFL-CIO
6800 North High Street
Worthington, Ohio 43085

Mr. Harold F. Mitchell
First Vice President
AFSCME Ohio Council 8, AFL-CIO
6800 North High Street
Worthington, Ohio 43085

Mr. Jack Filak
Regional Director
AFSCME Ohio Council 8, AFL-CIO
150 South Four Mile Run Rd.
Youngstown, Ohio 44515

Ms. Marcia Knox
Director of Field Services
AFSCME Ohio Council 8, AFL-CIO
15 Gates Street
Dayton, Ohio 45402

Ms. Pamela D. Brown
Cleveland Regional Vice President
President-AFSCME Local 1746
Cuyahoga County Department of Human Services
1603 East 27th Street
Cleveland, Ohio 44114

Mr. R. Sean Grayson
General Counsel
AFSCME Ohio Council 8, AFL-CIO
6800 North High Street
Worthington, Ohio 43085

Mr. Gary Martin
Associate Director
OAPSE/AFSCME Local 4, AFL-CIO
255 Trail East
Etna, Ohio 43062

If you wish to contact the Board of Trustees, you may do so in care of Ohio AFSCME Care Plan, 1603 East 27th Street, Cleveland, Ohio 44114.

The Board of Trustees is designated as the Plan Administrator. This means that the Board of Trustees is responsible for seeing that the information regarding the Plan is disclosed to Plan participants and beneficiaries and to governmental agencies in accordance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Day-to-day details for the Plan are handed for the Board of Trustees by the Plan Administrator who may be reached at 1603 East 27th Street, Cleveland, Ohio 44114, (216) 781-6420.

Plan participants and beneficiaries may write to the Board of Trustees to find out if a particular employer is one of the contributing employers on behalf of participants working under a collective bargaining agreement, and, if so, to find out the employer's address. The Plan is maintained pursuant to collective bargaining agreements, and Plan participants may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees.

The Plan's benefits for eligible participants are provided through employer contributions made to the Plan under either the applicable collective bargaining agreement or participation agreement.

All assets of the Plan are held in Trust by the Board of Trustees. The Plan is an employee welfare benefit Plan maintained for the purpose of providing, as applicable in each collective bargaining agreement or participation agreement, loss of life benefits, including accidental death and dismemberment benefits, dental benefits, vision benefits, hearing aid benefits, and prescription drug benefits. A detailed written description of the Plan benefits that you, as a participant, are entitled to, is available at the Plan's administrative office, and you may also obtain a free copy of the booklets that describe the benefits available to you by writing or calling the administrative office at the address and telephone number shown above. If you wish to inspect or receive copies of any documents relating to the Plan, contact the Plan administrative office. You will be charged a reasonable fee to cover the cost of any material you wish to receive.

The number assigned to the Board of Trustees by the Internal Revenue Service is 34-6726788, the number assigned to the Plan by the Board of Trustees is 501. The financial records of the Plan are maintained on a fiscal period commencing March 1 and ending on the following February 28 of each year.

The Plan provides for different benefits for different groups of employees. The benefits available to you vary according to the collective bargaining agreement or participation agreement under which you are working. The rules which describe your eligibility for benefits are contained in the Plan description booklets issued to you. If you have any questions concerning your eligibility, you may call or write the Plan administrative office.

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights of plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or for exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within a certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the mate-

rials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IX. CLAIMS FILING AND APPEAL PROCEDURE

To make a claim for benefits under this Plan, follow these instructions:

Filing of Claims. To be reimbursed for all benefits, obtain a claim form from the Plan administrative office or submit a claim form provided by your dentist.

All claims submitted must be accompanied by any bills, proof, or information reasonably required to process the claim submitted.

Upon receipt of the completed forms, a decision on your claim will be made within ninety (90) days. If further time is required for a decision, you will be notified with an explanation of why more time is necessary, and in that case, a decision then will be made on your claim within one hundred eighty (180) days after receipt of your completed application.

Appeal and Review Procedure. If your claim for benefits is denied in whole or in part, you will receive written notification stating the specific reason or reasons for the denial, specific reference to Plan provisions on which the denial is based, and, if applicable, a description of any additional material or information necessary to complete the claim with an explanation of why the material or information is required. You will also receive an explanation of the claims appeal procedure.

If you are not satisfied, or do not agree with the reasons for the denial of your claim, you may appeal and request a review within sixty (60) days of the date you

received the letter denying your claim. The appeal must be in writing, and can be made either by you or your authorized representative. In it you must set out your disagreement. You may also request an opportunity to review necessary and pertinent documents which may affect your appeal.

Who Is Responsible to Make a Decision on Your Appeal? The review shall be by the Board of Trustees of the Plan. Send your appeal to:

Board of Trustees
Ohio AFSCME Care Plan
1603 East 27th Street
Cleveland, Ohio 44114

An applicant who has not received a decision on his claim for benefits within ninety (90) days (or one hundred eighty [180] days if you have been notified of special circumstances) may request a review of his claim.

Your claim appeal will be promptly reviewed, and you will be advised of a decision within sixty (60) days after receipt of your appeal, unless special circumstances require an extension of time for processing, in which case a decision shall be made within one hundred twenty (120) days. The decision will be in writing and will include the specific reasons for the decision and specific references to Plan provisions on which the decision is based.

TABLE OF ALLOWANCES FOR DENTAL PROCEDURES

The procedures included in the “Code for Most Frequently Reported Dental Procedures” are the procedures most often benefited under dental Plans and therefore remain the principal administrative aid to most dentists and their office staffs. It is printed here for convenient reference.

Coding System. The code is a five-digit system to identify dental procedures and services. The basic categories are:

Category of Service	Code Series
I. Diagnostic	D0100-D0999
II. Preventive	D1000-D1999
III. Restorative	D2000-D2999
IV. Endodontics	D3000-D3999
V. Periodontics	D4000-D4999
VI. Prosthodontics, removable	D5000-D5999
VII. Prosthodontics, fixed	D6000-D6999
VIII. Oral and Maxillofacial surgery	D7000-D7999
IX. Orthodontics	D8000-D8999
X. Adjunctive General Services Implant Services	D9000-D9999

OHIO AFSCME CARE PLAN SCHEDULE OF BENEFITS

Level II-A

D0100-D0999 I. DIAGNOSTICS

Max. Allowance

CLINICAL ORAL EXAMINATIONS

D0110	Initial Examination	24.00
D0120	Periodic Oral Examination.....	24.00
D0140	Limited Oral Evaluation-Problem Focusing	38.00
D0150	Comprehensive Oral Examination.....	39.00

RADIOGRAPHS

D0210	Intraoral Complete Series-Including Bitewings.....	66.00
D0220	Intraoral-Periapical-First Film	13.00
D0230	Intraoral Periapical-Each Additional Film.....	11.00
D0240	Intraoral Occlusal Film.....	20.00
D0250	Extraoral-First Film	27.00
D0260	Extraoral-Each Additional Film	26.00
D0270	Bitewing-Single Film	14.00
D0272	Bitewing-Two Films.....	22.00
D0273	Bitewing-Three Films.....	26.00
D0274	Bitewing-Four Films	34.00
D0290	Posterior-Anterior or Lateral Skull & Facial Bone Survey Film.....	95.00
D0310	Sialography	68.00
D0330	Panoramic Film	58.00
D0340	Cephalometric Film	70.00

TESTS AND LABORATORY EXAMINATIONS

D0415	Bacteriological Studies for Determination of Pathologic Agents.....	CT/L
D0460	Pulp Vitality Tests	26.00
D0470	Diagnostic Casts	55.00
D0471	Diagnostic Photos	35.00
D0501	Histopathologic Examinations	40.00
D0502	Other Oral Pathology Procedures	BR
D0999	Unspecified Diagnostic Procedures.....	CT/L

D1000-D1999 II. PREVENTIVE

DENTAL PROPHYLAXIS

D1110	Prophylaxis-Adults.....	48.00
D1120	Prophylaxis-Child.....	33.00

TOPICAL FLUORIDE APPLICATION TREATMENT – Office Procedure

D1201	Topical Application of Fluoride (Including Prophylaxis-Child)	47.00
D1203	Topical Application of Fluoride (Excluding Prophylaxis-Child)	19.00
D1204	Topical Application of Fluoride (Excluding Prophylaxis-Adult)	20.00
D1205	Topical Application of Fluoride (Including Prophylaxis-Adult)	69.00

OTHER PREVENTIVE SERVICES

D1310	Nutritional Counseling for Control of Dental Disease	29.00
D1330	Oral Hygiene Instruction.....	19.00
D1351	Sealant-Per Tooth-Through Age 16	27.00

SPACE MAINTENANCE (Passive Appliance)

D1510	Space Maintainer-Fixed Unilateral.....	140.00
D1515	Space Maintainer-Fixed Bilateral.....	202.00
D1520	Space Maintainer-Removable Unilateral	164.00
D1525	Space Maintainer-Removable Bilateral	221.00
D1550	Recement Space Maintainer	34.00

D2000-D2999 III. RESTORATIVE

AMALGAM RESTORATIONS (Including Polishing)

D2110	Amalgam-One Surface-Primary	46.00
D2120	Amalgam-Two Surfaces-Primary	60.00
D2130	Amalgam-Three Surfaces-Primary	71.00
D2131	Amalgam-Four or More Surfaces-Primary.....	80.00
D2140	Amalgam-One Surface-Permanent	52.00
D2150	Amalgam-Two Surfaces-Permanent	64.00
D2160	Amalgam-Three Surfaces-Permanent.....	76.00
D2161	Amalgam-Four or More Surfaces-Permanent	96.00

SILICATE RESTORATIONS

D2210	Silicate Cement-Per Restoration	23.00
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FILLED OR UNFILLED RESIN RESTORATIONS

D2330	Resin-One Surface-Anterior	60.00
D2331	Resin-Two Surfaces-Anterior.....	76.00
D2332	Resin-Three Surfaces-Anterior.....	96.00
D2335	Resin-Four or More Surfaces or Involving Incisal Angle.....	112.00
D2336	Composite Resin Crown-Anterior-Primary.....	120.00
D2380	Resin-One Surface-Posterior-Primary	58.00
D2381	Resin-Two Surfaces-Posterior-Primary	80.00
D2382	Resin-Three or More Surfaces-Posterior-Primary	96.00
D2385	Resin-One Surface-Posterior-Permanent	68.00
D2386	Resin-Two Surfaces-Posterior-Permanent.....	92.00
D2387	Resin-Three or More Surfaces-Posterior-Permanent	116.00
D2388	Resin-Four or More Surfaces-Posterior-Permanent	136.00

INLAY RESTORATIONS

D2510	Inlay-Metallic-One Surface	192.00
D2520	Inlay-Metallic-Two Surfaces.....	217.00
D2530	Inlay-Metallic-Three or More Surfaces.....	250.00
D2543	Onlay-Metallic-Three Surfaces	260.00
D2544	Onlay-Metallic-Four or More Surfaces.....	270.00
D2610	Inlay-Porcelain/Ceramic-One Surface	227.00
D2620	Inlay-Porcelain/Ceramic-Two Surfaces.....	240.00

D2630	Inlay-Porcelain/Ceramic-Three Surfaces	257.00
D2642	Onlay-Porcelain/Ceramic-Two Surfaces	250.00
D2643	Onlay-Porcelain/Ceramic-Three Surfaces	270.00
D2644	Onlay-Porcelain/Ceramic-Four or More Surfaces	285.00
D2650	Inlay-Composite/Resin-One Surface-Lab	107.00
D2651	Inlay-Composite/Resin-Two Surfaces-Lab.....	138.00
D2652	Inlay-Composite/Resin-Three or More Surfaces-Lab	168.00
D2662	Onlay-Composite/Resin-Two Surfaces-Lab.....	195.00
D2663	Onlay-Composite/Resin-Three Surfaces-Lab.....	227.00
D2664	Onlay-Composite/Resin-Four or More Surfaces-Lab.....	245.00

CROWNS-SINGLE RESTORATION ONLY

D2710	Crown-Resin-Laboratory	127.00
D2720	Crown-Resin with High Noble Metal.....	300.00
D2721	Crown-Resin with Predominantly Base Metal.....	300.00
D2722	Crown-Resin with Noble Metal	300.00
D2740	Crown-Porcelain/Ceramic Substrate	300.00
D2750	Crown-Porcelain Fused to High Noble Metal.....	290.00
D2751	Crown-Porcelain Fused to Predominantly Base Metal.....	275.00
D2752	Crown-Porcelain Fused to Noble Metal	275.00
D2790	Crown-Full Cast Noble Metal.....	275.00
D2791	Crown-Full Cast Predominantly Base Metal	275.00
D2792	Crown-Full Cast Noble Metal.....	275.00

OTHER RESTORATIVE SERVICES

D2910	Recement Inlay	25.00
D2920	Recement Crown.....	25.00
D2930	Prefabricated Stainless Steel Crown-Primary Tooth	70.00
D2931	Prefabricated Stainless Steel Crown-Permanent Tooth	70.00
D2932	Prefabricated Resin Crown.....	70.00
D2933	Prefabricated Stainless Steel Crown-With Resin Window	70.00
D2940	Sedative Filling.....	27.00
D2950	Core Buildup-Including any Pins	65.00
D2951	Pin Retention-Per Tooth in Addition to Restoration.....	17.00
D2952	Cast Post & Core in Addition to Crown	100.00
D2954	Prefabricated Post & Core in Addition to Crown	82.00
D2955	Post Removal-Not in Conjunction with Endodontic Therapy	70.00
D2960	Labial Veneer (Resin Laminate) - Chairside.....	140.00
D2961	Labial Veneer (Resin Laminate) - Laboratory	96.00
D2962	Labial Veneer (Porcelain Laminate) - Laboratory	250.00
D2970	Temporary Crown (Fractured Tooth).....	50.00
D2980	Crown Repair, By Report	50.00
D2999	Unspecified Restorative Procedure, By Report	50.00

D3000-D3999 IV. ENDODONTICS

PULP CAPPING

D3110	Pulp Cap-Direct (Excluding Final Restoration.....	15.00
D3120	Pulp Cap-Indirect (Excluding Final Restoration	15.00

PULPOTOMY

D3220	Therapeutic Pulpotomy (Excluding Final Restoration).....	33.00
D3230	Pulpal Therapy-Anterior-Primary Teeth.....	60.00
D3240	Pulpal Therapy-Posterior-Primary Tooth.....	75.00

ROOT CANAL THERAPY (Includes Primary Teeth Without Succedaneous Teeth and Permanent Teeth. Pulpectomy is Part of Root Canal Therapy – Including Treatment Plan, Clinical Procedures, and Follow-up Care)

D3310	Anterior Root Canal (Excluding Final Restoration).....	190.00
D3320	Bicuspid Root Canal (Excluding Final Restoration).....	232.00
D3330	Molar Root Canal (Excluding Final Restoration).....	290.00
D3346	Retreatment-Anterior, By Report.....	245.00
D3347	Retreatment-Bicuspid, By Report.....	290.00
D3348	Retreatment-Molar, By Report.....	350.00
D3351	Apexification/Recalcification-Initial Visit (Apical Closure/Calcific Repair of Perforations, Root Resorption, Etc.).....	CT/S
D3352	Apexification/Recalcification-Interim Medication Replacement (Apical Closure/Calcific Repair of Perforations, Root Resorption, Etc.).....	CT/S
D3353	Apexification/Recalcification-First Visit (Includes Complete Root Canal Therapy, Apical Closure/Calcific Repair of Perforations, Root Resorption, Etc.).....	CT/S

PERIAPICAL SERVICES

D3410	Apicoectomy/Periradicular Surgery-Anterior.....	210.00
D3421	Apicoectomy/Periradicular Surgery-Bicuspid (First Root).....	210.00
D3425	Apicoectomy/Periradicular Surgery-Molar (First Root).....	210.00
D3426	Apicoectomy/Periradicular Surgery-(Each Additional Root).....	87.00
D3430	Retrograde Filling-Per Root.....	63.00
D3450	Root Amputation-Per Root.....	140.00
D3470	Intentional Reimplantation (Including Splinting).....	CT/S

OTHER ENDODONTIC PROCEDURES

D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam.....	13.00
D3920	Hemisection (Including Any Root Removal) Not Including Root Canal Therapy ...	84.00
D3950	Canal Preparation and Fitting of Preformed Dowel or Post.....	CT/PS
D3960	Bleaching of Discolored Teeth - (Nonvital).....	36.00
D3999	Unspecified Endodontic Procedure, By Report.....	33.00

D4000-D4999 V. PERIODONTICS

SURGICAL SERVICES (Including Usual Postoperative Care)

D4210	Gingivectomy/Gigivoplasty-Per Quadrant.....	CT/TPS
D4211	Gingivectomy/Gigivoplasty-Per Tooth.....	CT/TPS
D4220	Gingival Curettage Surgical-Per Quadrant By Report.....	CT/TPS
D4240	Gingival Flap Procedure, Including Root Planing-Per Quadrant.....	CT/TPS
D4249	Clinical Crown Lengthening-Hard Tissue.....	CT/TPS
D4250	Mucogingival Surgery-Per Quadrant.....	CT/TPS
D4260	Osseous Surgery (Including Flap Entry and Closure) - Per Quadrant.....	CT/TPS
D4263	Bone Replacement Graft-First Site in Quadrant.....	CT/TPS
D4264	Bone Replacement Graft-Each Additional Site in Quadrant.....	CT/TPS
D4266	Guided Tissue Regeneration-Resorbable Barrier, Per Site, Per Tooth.....	CT/TPS
D4267	Guided Tissue Regeneration-Nonresorbable Barrier, Per Site, Per Tooth (Includes Membrane Removal).....	CT/TPS

D4270	Pedicle Soft Tissue Graft Procedure	CT/TPS
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	CT/TPS
D4273	Subepithelia Connective Tissue Graft Procedure (Including Donor Site Surgery)	CT/TPS
D4274	Distal or Proximal Wedge Procedure (When Not Performed in Conjunction with Surgical Procedures in Same Anatomical Area)	CT/TPS

ADJUNCTIVE PERIODONTAL PROCEDURES

D4320	Provisional Splinting-Intracoronal	CT/TPS
D4321	Provisional Splinting-Extracoronal	CT/TPS
D4341	Scaling & Root Planing-Per Quadrant	CT/TPS
D4355	Full Mouth Debridement	CT/TPS
D4381	Localized Delivery of Chemotherapeutic Agents Via a Controlled Release Vehicle . Into Diseased Crevicular Tissue, Per Tooth, Per Site	CT/TPS

OTHER PERIODONTAL PROCEDURES

D4910	Periodontal Maintenance Procedures (Following Active Therapy)	37.00
D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist)	30.00
D4999	Unspecified Periodontal Procedure (By Report)	CT/TPS

D5000-D5999 VI. PROSTHODONTICS (Removable)

COMPLETE DENTURES (Including Routine Postdelivery Care)

D5110	Complete Denture-Maxillary	365.00
D5120	Complete Denture-Mandibular	365.00
D5130	Immediate Denture-Maxillary	400.00
D5140	Immediate Denture-Mandibular	400.00

PARTIAL DENTURES (Including Routine Postdelivery Care)

D5211	Maxillary Partial Denture-Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	300.00
D5212	Mandibular Partial Denture-Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	350.00
D5213	Maxillary Partial Denture-Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests, and Teeth)	395.00
D5214	Mandibular Partial Denture-Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests, and Teeth)	395.00
D5281	Removable Unilateral Partial Denture-One Piece Cast Metal (Including Clasps and Teeth)	232.00

ADJUSTMENT TO DENTURES

D5410	Adjust Complete Denture-Maxillary	20.00
D5411	Adjust Complete Denture-Mandibular	20.00
D5421	Adjust Partial Denture-Maxillary	20.00
D5422	Adjust Complete Denture-Mandibular	20.00

REPAIRS TO COMPLETE DENTURES

D5510	Repair Broken Complete Denture Base	74.00
D5520	Replace Missing or Broken Teeth-Complete Denture (Each Tooth)	32.00

REPAIRS TO PARTIAL DENTURES

D5610	Repair Resin Denture Base	42.00
D5620	Repair Cast Framework	72.00

D5630	Repair or Replace Broken Clasp.....	55.00
D5640	Replace Broken Teeth-Per Tooth	35.00
D5650	Add Tooth to Existing Partial Denture.....	50.00
D5660	Add Clasp to Existing Partial Denture	57.00

DENTURE REBASE PROCEDURES

D5710	Rebase Complete Maxillary Denture.....	137.00
D5711	Rebase Complete Mandibular Denture	137.00
D5720	Rebase Maxillary/Partial Denture.....	137.00
D5721	Rebase Mandibular Partial Denture	137.00

DENTURE RELINE PROCEDURES

D5730	Reline Complete Maxillary Denture (Chairside)	75.00
D5731	Reline Complete Mandibular Denture (Chairside).....	75.00
D5740	Reline Maxillary Partial Denture (Chairside)	75.00
D5741	Reline Mandibular Partial Denture (Chairside).....	75.00
D5750	Reline Complete Maxillary Denture (Laboratory)	107.00
D5751	Reline Complete Mandibular Denture (Laboratory).....	107.00
D5760	Reline Maxillary Partial Denture (Laboratory)	107.00
D5761	Reline Mandibular Partial Denture (Laboratory).....	107.00

OTHER REMOVABLE PROSTHETIC SERVICES

D5810	Interim Complete Denture-Maxillary.....	135.00
D5811	Interim Complete Denture-Mandibular	135.00
D5820	Interim Partial Denture-Maxillary.....	135.00
D5821	Interim Partial Denture-Mandibular	135.00
D5850	Tissue Conditioning-Maxillary	35.00
D5851	Tissue Conditioning-Mandibular.....	35.00
D5860	Overdenture-Complete, By Report.....	CT/L
D5861	Overdenture-Partial, By Report.....	CT/L
D5862	Precision Attachment, By Report.....	CT/L
D5299	Unspecified Removable Prosthodontic Procedure, By Report.....	CT/L

D6200-D6999 VII. PROSTHODONTICS, FIXED

(Each Abutment and Each Pontic Constitutes a Unit In a Bridge)

BRIDGE PONTICS

D6210	Pontic-Cast High Noble Metal	270.00
D6211	Pontic-Cast Predominantly Base Metal	260.00
D6212	Pontic-Cast Noble Metal.....	270.00
D6240	Pontic-Porcelain Fused to High Noble Metal	275.00
D6241	Pontic-Porcelain Fused to Predominantly Base Metal	255.00
D6242	Pontic-Porcelain Fused to Noble Metal.....	270.00
D6250	Pontic-Resin with High Noble Metal	240.00
D6251	Pontic-Resin with Predominantly Base Metal	150.00
D6252	Pontic-Resin with Noble Metal.....	200.00

RETAINERS

D6520	Inlay-Metallic-Two Surfaces.....	240.00
D6530	Inlay-Metallic-Three or More Surfaces.....	175.00

D6543	Onlay-Metallic-Three Surfaces	282.00
D6544	Onlay-Metallic-Four or More Surfaces.....	295.00
D6545	Retainer-Cast Metal for Resin Bonded Fixed Prosthesis.....	112.00

BRIDGE RETAINERS - CROWNS

D6720	Crown-Resin With High Noble Metal	238.00
D6721	Crown-Resin With Predominantly Base Metal.....	275.00
D6722	Crown-Resin With Noble Metal.....	232.00
D6750	Crown-Porcelain Fused to High Noble Metal.....	300.00
D6751	Crown-Porcelain Fused to Predominantly Base Metal.....	290.00
D6752	Crown-Porcelain Fused to Noble Metal	295.00
D6780	Crown-3/4 Cast High Noble Metal.....	297.00
D6790	Crown-Full Cast High Noble Metal	297.00
D6791	Crown-Full Cast Predominantly Base Metal	295.00
D6792	Crown-Full Cast Noble Metal.....	287.00

OTHER FIXED PROSTHETIC SERVICES

D6920	Connector Bar	160.00
D6930	Recement Fixed Partial Denture	35.00
D6940	Stress Breaker.....	60.00
D6950	Precision Attachment.....	157.00
D6970	Cast Post and Core in Addition to Fixed Partial Denture Retainer.....	97.00
D6971	Cast Post as Part of Fixed Partial Denture Retainer	60.00
D6972	Prefabricated Post & Core in Addition to Fixed Partial Denture Retainer.....	80.00
D6973	Core Buildup for Retainer, Including Any Pins.....	65.00
D6975	Coping Metal	75.00
D6980	Fixed Partial Denture Repair, By Report	CT/L
D6999	Unspecified Fixed Prosthetic Procedure By Report.....	CT/L

D7000-D7999 VIII. ORAL AND MAXILLOFACIAL SURGERY

EXTRACTIONS – INCLUDES LOCAL ANESTHESIA, SUTURING IF NEEDED, AND ROUTINE POSTOPERATIVE CARE

D7110	Single Tooth.....	36.00
D7120	Each Additional Tooth.....	34.00
D7130	Root Removal – Exposed Roots	CT/S

SURGICAL EXTRACTIONS – INCLUDES LOCAL ANESTHESIA, SUTURING IF NEEDED, AND ROUTINE POSTOPERATIVE CARE

D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth).....	CT/S
D7220	Removal of Impacted Tooth-Soft Tissue	80.00
D7230	Removal of Impacted Tooth-Partially Bony.....	107.00
D7240	Removal of Impacted Tooth-Completely Bony.....	125.00
D7241	Removal of Impacted Tooth-Completely Bony With Unusual Surgical Complications.....	CT/S
D7250	Removal of Residual Tooth Roots (Cutting Procedure)	CT/S

OTHER SURGICAL PROCEDURES

D7260	Oroantral Fistula Closure	CT/S
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth and/or Alveolus	CT/S
D7272	Tooth Transplantation (Includes Reimplantation From One Side To Another and Splinting and/or Stabilization).....	CT/S
D7280	Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons (Including Orthodontic Attachments).....	CT/S
D7281	Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption	CT/S
D7285	Biopsy of Oral Tissue-Hard	CT/S
D7286	Biopsy of Oral Tissue-Soft.....	CT/S
D7290	Surgical Repositioning of Tooth.....	CT/S
D7291	Transseptal Fiberotomy, By Report	CT/S

ALVEOLOPLASTY-SURGICAL PREPARATION OF RIDGE FOR DENTURES

D7310	Alveoplasty in Conjunction with Extractions (Per Quadrant)	72.00
D7320	Alveoplasty Not in Conjunction with Extractions (Per Quadrant).....	66.00

VESTIBULOPLASTY

D7340	Vestibuloplasty-Ridge Extension (Secondary Epithelialization)	CT/S
D7350	Vestibuloplasty-Ridge Extension (Including Soft Tissue Grafts, Muscle Reattachment, Revision of Soft Tissue Attachment and Management of Hypertrophied and Hyperplastic Tissue) Surgical Excision of Reactive Inflammatory Lesions (Scar Tissue of Localized Congenital Lesions)	CT/S
D7410	Radical Excision-Lesion Diameter Up to 1.25 cm.....	CT/S
D7420	Radical Excision-Lesion Diameter Greater Than 1.25 cm	CT/S

REMOVAL OF TUMORS, CYSTS, AND NEOPLASMS

D7430	Excision of Benign Tumor-Lesion Diameter up to 1.25 cm.....	80.00
D7431	Excision of Benign Tumor-Lesion Diameter Greater Than 1.25 cm.....	CT/S
D7450	Removal of Odontogenic Cyst or Tumor Lesion Diameter up to 1.25 cm.....	75.00
D7451	Removal of Odontogenic Cyst or Tumor Lesion Diameter Greater Than 1.25 cm	CT/S
D7460	Removal of Nonodontogenic Cyst or Tumor Lesion Diameter up to 1.25 cm	72.00
D7461	Removal of Nonodontogenic Cyst or Tumor Lesion Diameter Greater Than 1.25 cm	CT/S
D7465	Destruction of Lesion(s) by Physical or Chemical Method, By Report.....	CT/S

EXCISION OF BONE TISSUE

D7470	Removal of Exostosis-Maxilla or Mandible	CT/S
D7480	Partial Osteotomy (Guttering or Saucerization).....	CT/S

SURGICAL INCISION

D7510	Isolation and Drainage of Abscess-Intraoral Soft Tissue.....	55.00
D7520	Incision and Drainage of Abscess-Extraoral Soft Tissue.....	CT/S
D7530	Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue	CT/S
D7540	Removal of Reaction-Producing Foreign Bodies-Musculoskeletal System ...	CT/S
D7550	Sequestrectomy for Osteomyelitis.....	CT/S
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body.....	CT/S

REPAIR OF TRAUMATIC WOUNDS

D7910	Suture of Recent Small Wounds up to 5 cm.....	35.00
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COMPLICATED SUTURING

(Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)

D7911 Complicated Suture-Up to 5 cm CT/S

OTHER REPAIR PROCEDURES

D7960 Frenulectomy (Frenectomy or Frenotomy) – Separate Procedure..... CT/S

D7970 Excision of Hyperplastic Tissue-Per Arch CT/S

D7971 Excision of Pericoronal Gingiva..... CT/S

D7999 Unspecified Oral Surgery Procedure, By Report..... CT/S

D9000-D9999 IX. ADJUNCTIVE GENERAL SERVICES

UNCLASSIFIED TREATMENT

D9110 Palliative (Emergency) Treatment of Dental Pain-Minor Procedure..... 25.00

ANESTHESIA

D9210 Local Anesthesia Not in Conjunction With Operative or Surgical Procedures..... 23.00

D9220 General Anesthesia-First 30 Minutes 100.00

D9221 General Anesthesia-Each Additional 15 Minutes..... 55.00

D9230 Analgesia, Anxiolysis, Inhalation of Nitrous Oxide-First 30 minutes 60.00

Each Additional 15 Minutes 32.00

D9240 Intravenous Sedation-First 30 Minutes..... 60.00

Each Additional 15 Minutes 32.00

PROFESSIONAL CONSULTATION (Diagnostic Service Provided by Dentist or Physician Other Than Practitioner Providing Treatment)

D9310 Consultation (Diagnostic Service Provided by Dentist or Physician Other Than Practitioner Providing Treatment)..... 30.00

PROFESSIONAL VISITS

D09410 House Call..... 30.00

D9420 Hospital Call 50.00

D9430 Office Visit for Observation (During Regularly Scheduled Hours) – No Other Services Performed 20.00

D9440 Office Visit-After Regularly Scheduled Hours 32.00

DRUGS

D9610 Therapeutic Drug Injection, By Report..... 17.00

D9630 Other Drugs and/or Medicaments, By Report..... 17.00

MISCELLANEOUS SERVICES

D9910 Application of Desensitizing Medicaments..... 15.00

D9920 Behavior Management, By Report..... CT/S

D9930 Treatment of Complications (Post-Surgical) – Unusual Circumstances, By Report..... CT/S

D9940 Occlusion Guard, By Report 140.00

D9941 Fabrication of Athletic Mouthguard..... 110.00

D9950 Occlusion Analysis-Mounted Case..... 47.00

D9951 Occlusion Adjustment-Limited..... 30.00

D9952 Occlusion Adjustment-Complete 90.00

D9999 Unspecified Adjunctive Procedure, By Report CT/S

IMPLANT SERVICES EFFECTIVE JULY 1, 2016.

D0364	Cone Beam CT Capture and Interpretation With Limited Field of View - Less Than One Whole Jaw.....	262.00
D0365	Cone Beam CT Capture and Interpretation With Field of One Full Dental Arch - Mandible.....	262.00
D0366	Cone Beam CT Capture and Interpretation With Field of One Full Dental Arch - Maxilla, With or Without Cranium	262.00
D0367	Cone Beam CT Capture and Interpretation With Field of View of Both Jaws; With or Without Cranium	262.00
D0368	Cone Beam CT Capture and Interpretation for TMJ Series Including Two or More Exposures	262.00
D0380	Cone Beam CT Image Capture With Limited Field of View - Less Than One Whole Jaw	172.00
D0381	Cone Beam CT Image Capture With Field of View of One Full Dental Arch - Mandible	172.00
D0382	Cone Beam CT Image Capture With Field of View of One Full Dental Arch - Maxilla, With or Without Cranium	172.00
D0383	Cone Beam CT Image Capture With Field of View of Both Jaws, With or Without Cranium	172.00
D4265	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration	38.00
D4275	Soft Tissue Allograft	63.00
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery), First Tooth or Edentulous Tooth Position in Graft	83.00
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery), Each Additional Contiguous Tooth or Edentulous Tooth Position in Same Graft Site	42.00
D4283	Autogenous CT Graft - Each Additional Contiguous Tooth Site	61.00
D4285	Non-Autogenous CT Graft - Each Additional Contiguous Tooth Site	32.00
D6010	Surgical Placement of Implant Body: Endosteal Implant	591.00
D6011	Second Stage Implant Surgery	41.00
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis:	
	Endosteal Implant	407.00
D6013	Surgical Placement of Mini Implant	591.00
D6040	Surgical Placement: Epostal Implant	1500.00
D6050	Surgical Placement: Transosteal Implant	1404.00
D6051	Interim Abutment	103.00
D6052	Semi-Precision Attachment Abutment	179.00
D6053	Implant/Abutment Supported Removable Denture for Completely Edentulous Arch	664.00
D6054	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch	650.00
D6055	Connecting Bar - Implant Supported or Abutment Supported	753.00
D6056	Prefabricated Abutment - Includes Modification and Placement	188.00
D6057	Custom Fabricated Abutment - Includes Placement	229.00
D6058	Abutment Supported Porcelain/Ceramic Crown	367.00
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	367.00
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)	349.00
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)	355.00
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	367.00

D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	343.00
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	350.00
D6065	Implant Supported Porcelain/Ceramic Crown	386.00
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	391.00
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	396.00
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD	369.00
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)	370.00
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)	346.00
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)	351.00
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)	367.00
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)	348.00
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)	349.00
D6075	Implant Supported Retainer for Ceramic FPD	387.00
D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)	392.00
D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)	393.00
D6078	Implant/Abutment Supported Fixed Denture for Completely Edentulous Arch	1495.00
D6079	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch ...	1067.00
D6080	Implant Maintenance Procedures When Prostheses Are Removed and Reinserted, Including Cleansing of Prosthesis and Abutments	74.00
D6090	Repair Implant Supported Prosthesis (By Report)	189.00
D6091	Replacement of Semi-Precision or Precision Attachment (Male or Female Compo- nent) of Implant/Abutment Supported Prosthesis, per Attachment	154.00
06092	Recent Implant/Abutment Supported Crown	25.00
D6093	Recent Implant/Abutment Supported Fixed Partial Denture	35.00
06094	Abutment Supported Crown - (Titanium)	341.00
D6100	Implant Removal (By Report)	64.00
D6101	Debridement of a Periimplant Defect and Surface Cleaning of Exposed Implant Surfaces, Including Flap Entry and Closure	135.00
D6102	Debridement and Osseous Contouring of a Periimplant Defect; Includes Surface Cleaning of Exposed Implant Surfaces, Including Flap Entry and Closure	178.00
D6103	Bone Graft for Repair of Periimplant Defect - Not Including Flap Entry and Closure or, When Indicated, Placement of a Barrier Membrane or Biologic Materials to Aid in Osseous Regeneration	160.00
D6104	Bone Graft at Time of Implant Placement	153.00
D6110	Implant/Abutment Supported Removable Denture for Edentulous Arch - Maxillary	365.00
D6111	Implant/Abutment Supported Removable Denture for Edentulous Arch - Mandibular	365.00

D6112	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch - Maxillary	395.00
D6113	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch - Mandibular	395.00
D6114	Implant/Abutment Supported Fixed Denture for Edentulous Arch - Maxillary	BR
D6115	Implant/Abutment Supported Fixed Denture for Edentulous Arch - Mandibular	BR
D6116	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch - Maxillary	BR
D6117	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch - Mandibular	BR
D6190	Radiographic/Surgical Implant Index (By Report)	96.00
D6205	Pontic - Indirect Resin Based Composite	255.00
D6214	Pontic - Titanium.....	276.00
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	271.00
D6242	Pontic - Porcelain Fused to Noble Metal.....	278.00
D6245	Pontic - Porcelain/Ceramic	311.00
D6250	Pontic - Resin With High Noble Metal.....	280.00
D6251	Pontic - Resin With Predominantly Base Metal	273.00
D6252	Pontic - Resin With Noble Metal	274.00
D6253	Provisional Pontic - Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression.....	185.00
D7295	Harvest of Bone for Use In Autogenously Grafting Procedure (Coverage Only for Implant).....	117.00
D7950	Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Maxilla - Autogenous or Nonautogenous (By Report) (Coverage Only for Implant)	721.00
D7951	Sinus Augmentation With Bone or Bone Substitutes Via a Lateral Open Approach (Coverage Only for Implant).....	742.00
D7952	Sinus Augmentation Via a Vertical Approach (Coverage Only for Implant) ...	326.00
D7953	Bone Replacement Graft for Ridge Preservation - Per Site (Coverage Only for Implant)	149.00
D9223	Deep Sedation/General Anesthesia - Each 15 Minute Increment.	52.00
D9243	IV Moderate Sedation/Analgesia.....	102.00

IMPORTANT NOTICE

**It is important that you
contact the Plan Office to:**

- 1. Fill out an ENROLLMENT CARD.**
- 2. Change your home address
whenever you move.**

**For further information call or write
OHIO AFSCME CARE PLAN**

CLEVELAND

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Michael D. Bauer, Plan Administrator

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