



Voluntary Dental Benefits

Elite Choice 75 – Indemnity Plan

- Select any Licensed Dentist
- \$50 annual deductible per person (waived on preventive services)
- \$1000 annual maximum benefit per person
- No waiting periods on Type I, II and III services
- Claim Forms to File – Please note the address for claims: *CompBenefits Corporation, P.O. Box 8236, Chicago, IL 60680-8236*

Cost Per Pay Period

Employee Only	\$12.00
Employee + One	\$20.00
Employee + Family	\$28.00

**These are benefit plan highlights only:
Please refer to the plan schedules for complete description of benefits.**

HOW TO ENROLL

Contact: Buddy Murk
16164 Walnut Creek
San Antonio, TX 78247
Bus: 210-490-6317
Cell: 210-834-6875
budman007@att.net

WHEN AM I ELIGIBLE? *

You must have two (2) deductions by the 15th of the month for eligibility to begin the first of the following month. If at any time you have a change of address, or phone number, notify Benefit Architects. If you take a leave of absence due to injury, etc. please be advised that you will be responsible for making arrangements to pay for your coverage until your allotments begin again.

QUESTIONS, CALL 1-210-834-6875

CompBenefits Insurance Company ELITE SCHEDULE 75

Plan Design Summary

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

TYPE I - PREVENTIVE DENTAL SERVICES

ADA CODES	PROCEDURE	MAXIMUM REIMBURSEMENT
0120	PERIODIC ORAL EVALUATION (covered twice per 12 consecutive months)	\$21
0210	INTRAORAL-COMPLETE SERIES INCLUDING BITEWINGS (covered once per 3 year period)	50
0220	INTRAORAL-PERIAPICAL-FIRST FILM	10
0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	8
0240	INTRAORAL-OCCLUSAL FILM	11
0250	EXTRAORAL-FIRST FILM	10
0260	EXTRAORAL-EACH ADDITIONAL FILM	13
0270	BITEWINGS-SINGLE FILM (covered twice per 12 consecutive months)	12
0272	BITEWINGS-TWO FILMS (covered twice per 12 consecutive months)	16
0274	BITEWINGS-FOUR FILMS (covered twice per 12 consecutive months)	22
0290	POSTERIOR/ANTERIOR/LATERAL SKULL/FACIAL BONE SURVEY FILM	43
0330	PANORAMIC FILM (covered once per 3 year period)	44
0415	BACTERIOLOGIC STUDIES (pathologic agents)	13
1110	PROPHYLAXIS-ADULT (covered twice per 12 consecutive months)	32
1120	PROPHYLAXIS-CHILD (covered twice per 12 consecutive months)	26
1201	TOPICAL FLUORIDE application-CHILD (including prophylaxis) (covered twice per 12 consecutive months, but only for a dependent child under age 16)	38
1203	TOPICAL FLUORIDE application-CHILD (excluding prophylaxis) (covered twice per 12 consecutive months, but only for a dependent child under age 16)	13
1351	SEALANT-PER TOOTH (covered once per 12 consecutive months for dependent child under age 13)	16
1510	SPACE MAINTAINER-FIXED-UNILATERAL	131
1515	SPACE MAINTAINER-FIXED-BILATERAL	231
1520	SPACE MAINTAINER-REMOVABLE-UNILATERAL	170
1525	SPACE MAINTAINER-REMOVABLE-BILATERAL	200
1550	RECEMENTATION OF SPACE MAINTAINER	32
7285	BIOPSY OF ORAL TISSUE-HARD	105
7286	BIOPSY OF ORAL TISSUE-SOFT	105
9110	PALLIATIVE TREATMENT (covered as a separate procedure only if no other service, except x-rays is rendered during the visit)	32

TYPE II - BASIC DENTAL SERVICES

2110	AMALGAM-ONE SURFACE, PRIMARY*	\$34
2120	AMALGAM-TWO SURFACES, PRIMARY*	43
2130	AMALGAM-THREE SURFACES, PRIMARY*	54
2131	AMALGAM-FOUR OR MORE SURFACES, PRIMARY*	71
2140	AMALGAM-ONE SURFACE, PERMANENT*	32
2150	AMALGAM-TWO SURFACES, PERMANENT*	42
2160	AMALGAM-THREE SURFACES, PERMANENT*	53
2161	AMALGAM-FOUR OR MORE SURFACES, PERMANENT*	63
	*(multiple restorations on one surface will be covered as a single filling)	
2210	SILICATE CEMENT-PER RESTORATION**	21
2330	RESIN-ONE SURFACE, ANTERIOR**	37
2331	RESIN-TWO SURFACES, ANTERIOR**	47
2332	RESIN-THREE SURFACES, ANTERIOR**	58
2335	RESIN-FOUR + SURFACES OR INVOLVING INCISAL ANGLE**	63
2380	RESIN-ONE SURFACE, POSTERIOR-PRIMARY**	42
2381	RESIN-TWO SURFACES, POSTERIOR-PRIMARY**	57
2382	RESIN-THREE OR MORE SURFACES, POSTERIOR-PRIMARY**	65
2385	RESIN-ONE SURFACE, POSTERIOR-PERMANENT**	42
2386	RESIN-TWO SURFACES, POSTERIOR-PERMANENT**	63
2387	RESIN-THREE OR MORE SURFACES, POSTERIOR-PERMANENT**	76
	**(mesial-lingual, distal-lingual, mesial-buccal, & distal-buccal restorations on anterior teeth will be deemed single surface restorations)	
2910	RECEMENT INLAY	25
2920	RECEMENT CROWN	29
2940	SEDATIVE FILLING	34
2950	CORE BUILD-UP, INCLUDING ANY PINS	84

TYPE II - BASIC DENTAL SERVICES (CONT.)

ADA CODES	PROCEDURE	MAXIMUM REIMBURSEMENT
2951	PIN RETENTION/PER TOOTH, IN ADDITION TO RESTORATION	\$19
3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)	55
3310	ROOT CANAL-ANTERIOR	210
3320	ROOT CANAL-BICUSPID	242
3330	ROOT CANAL-MOLAR	273
3351	APEXIFICATION/RECALCIFICATION-INITIAL VISIT	84
3352	APEXIFICATION/RECALCIFICATION-INITIAL INTERIM MEDICATION	84
3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT	84
3410	APICOECTOMY/PERIRADICULAR SURGERY- ANTERIOR	248
3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID	210
3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR	210
3430	RETROGRADE FILLING-PER TOOTH	67
3450	ROOT AMPUTATION-PER ROOT	168
3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL)	155
4210	GINGIVECTOMY OR GINGIVOPLASTY-PER QUADRANT***	105
4211	GINGIVECTOMY OR GINGIVOPLASTY-PER TOOTH***	63
4220	GINGIVAL CURETTAGE, SURGICAL, PER QUADRANT***	42
4240	GINGIVAL FLAP PROCEDURE, PER QUADRANT***	158
4250	MUCOGINGIVAL SURGERY-PER QUADRANT***	134
	*** (only one of these procedures is covered per area of the mouth per 12 consecutive months)	
4260	OSSEOUS SURGERY-PER QUADRANT	315
4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	311
4271	FREE SOFT TISSUE GRAFT PROCEDURE	302
4320	PROVISIONAL SPLINTING-INTRACORONAL	118
4321	PROVISIONAL SPLINTING-EXTRACORONAL	84
4341	PERIODONTAL SCALING/ROOT PLANING-PER QUADRANT (covered twice per area of the mouth per 12 consecutive months)	74
4910	PERIODONTAL MAINTENANCE PROCEDURES (covered twice per area of the mouth per 12 consecutive months)	42
5510	REPAIR BROKEN COMPLETE DENTURE BASE ****	46
5520	REPLACE MISSING/BROKEN TEETH-COMPLETE DENTURE****	42
5610	REPAIR RESIN SADDLE OR BASE****	55
5620	REPAIR CAST FRAMEWORK****	46
5630	REPAIR OR REPLACE BROKEN CLASP****	71
5640	REPLACE BROKEN TEETH-PER TOOTH****	46
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE****	67
5660	ADD CLASP TO EXISTING PARTIAL DENTURE****	75
5710	REBASE COMPLETE UPPER DENTURE****	84
5711	REBASE COMPLETE LOWER DENTURE****	84
5720	REBASE UPPER PARTIAL DENTURE****	84
5721	REBASE LOWER PARTIAL DENTURE****	84
	**** (covered only if repairs/adjustments are done more than 1 year after the initial insertion)	
6930	RECEMENT BRIDGE	42
7110	EXTRACTION-SINGLE TOOTH	38
7120	EXTRACTION-EACH ADDITIONAL TOOTH	36
7210	SURGICAL REMOVAL OF ERUPTED TOOTH	76
7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	109
7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	153
7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	164
7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	63
7270	TOOTH REIMPLANTATION	86
7272	TOOTH TRANSPLANTATION	84
7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS-PER76 QUADRANT	76
7320	ALVEOLOPLASTY NOT IN CONJUNC WITH EXTRACTIONS-PER QUADRANT	96
7340	VESTIBULOPLASTY-RIDGE EXTEN(SECONDARY EPITHELIZTN)	151
7350	VESTIBULOPLASTY-RIDGE EXTEN (W/SOFT TISS GFT)	168
7510	I & D ABSCESS INTRAORAL-SOFT TISSUE	50
7520	I & D ABSCESS-EXTRAORAL SOFT TISSUE	76
7960	FRENULCTOMY (FRENECTOMY/FRENOTOMY) SEPARATE PROCEDURE	147
7970	EXCISION OF HYPERPLASTIC TISSUE/ PER ARCH	92
9220	GENERAL ANESTHESIA-FIRST 30 MINUTES	116
9221	GENERAL ANESTHESIA-EACH ADDITIONAL 15 MINUTES	79
9610	THERAPEUTIC DRUG INJECTION	17
9951	OCCCLUSION ADJUSTMENT-LIMITED	29
9952	OCCCLUSION ADJUSTMENT-COMPLETE	126

TYPE III - MAJOR DENTAL SERVICES

ADA CODES	PROCEDURE	MAXIMUM REIMBURSEMENT
470	DIAGNOSTIC CASTS	\$20
2510	INLAY-METALLIC-ONE SURFACE	147
2520	INLAY-METALLIC-TWO SURFACES	171
2530	INLAY-METALLIC-THREE OR MORE SURFACES	204
2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	142
2620	INLAY-PORCELAIN/CERAMIC-TWO SURFACES	158
2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES	173
2710	CROWN-RESIN-LABORATORY	50
2720	CROWN-RESIN W/HIGH NOBLE METAL	105
2721	CROWN-RESIN W/PREDOMINANTLY BASE METAL	95
2722	CROWN-RESIN W/NOBLE METAL	100
2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	250
2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	226
2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	210
2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	224
2790	CROWN-FULL CAST HIGH NOBLE METAL	236
2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	213
2792	CROWN-FULL CAST NOBLE METAL	224
2810	CROWN-3/4 CAST METALLIC	250
2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	50
2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	56
2952	CAST POST AND CORE IN ADDITION TO CROWN	74
2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	71
2970	TEMPORARY CROWN (FRACTURED TOOTH)	50
3426	APICECTOMY/PERIRADICULAR SURGERY-EACH ADDITIONAL ROOT	121
5110	COMPLETE DENTURE-MAXILLARY	261
5120	COMPLETE DENTURE-MANDIBULAR	259
5130	IMMEDIATE DENTURE-MAXILLARY	289
5140	IMMEDIATE DENTURE-MANDIBULAR	277
5211	MAXILLARY PART DENTURE-RESIN BASE (CLASP/RESTS)	313
5212	MANDIBULAR PART DENTURE-RESIN BASE (CLASP/RESTS)	315
5213	MAXILLARY PART DENTURE-METAL FRAME W/RESIN BASE	236
5214	MANDIBULAR PART DENTURE-METAL FRAME W/RESIN BASE	236
5281	REMOV UNILAT PART DENTURE-1 PIECE METAL (W/TEETH)	126

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

ADA CODES	PROCEDURE	MAXIMUM REIMBURSEMENT
5410	ADJUST COMPLETE DENTURE-MAXILLARY	\$15
5411	ADJUST COMPLETE DENTURE-MANDIBULAR	16
5421	ADJUST PARTIAL DENTURE-MAXILLARY	14
5422	ADJUST PARTIAL DENTURE-MANDIBULAR	15
5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	58
5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	66
5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	63
5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	63
5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	81
5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	82
5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	84
5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	79
6210	PONTIC-CAST HIGH NOBLE METAL	236
6211	PONTIC-CAST PREDOMINANTLY BASE METAL	197
6212	PONTIC-CAST NOBLE METAL	203
6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	224
6241	PONTIC-PORCELAIN FUSED TO PREDOM. BASE METAL	210
6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	224
6250	PONTIC-RESIN W/HIGH NOBLE METAL	224
6251	PONTIC-RESIN W/predominantly base metal	213
6252	PONTIC-RESIN W/NOBLE METAL	218
6520	RETAINER-INLAY-METALLIC-TWO SURFACES	184
6530	RETAINER-INLAY-METALLIC-THREE OR MORE SURFACES	210
6720	CROWN-RESIN W/HIGH NOBLE METAL	184
6721	CROWN-RESIN W/PREDOMINANTLY BASE METAL	171
6722	CROWN-RESIN W/NOBLE METAL	184
6750	CROWN-RETAINER-PORCELAIN FUSED HIGH NOBLE METAL	224
6751	CROWN-RETAINER-PORCELAIN FUSED PRED. BASE METAL	210
6752	CROWN-RETAINER-PORCELAIN FUSED TO NOBLE METAL	224
6780	CROWN-RETAINER 3/4 CAST HIGH NOBLE METAL	211
6790	CROWN-RETAINER-FULL CAST HIGH NOBLE METAL	239
6791	CROWN-RETAINER-FULL CAST PREDOM. BASE METAL	208
6792	CROWN-RETAINER-FULL CAST NOBLE METAL	218

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

Group's plan may include Orthodontics coverage for an additional fee. Not all plans have Type IV coverage.

Type IV Orthodontics (Optional)50% (12 month waiting period)**

Dependent children 18 years of age or younger

MAJOR RESTORATIVE LIMITATIONS

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

- the denture or partial denture must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
- the fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
- 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 implantor 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. Chewing injuries are not considered Covered Dental Injuries;
- the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if:
- replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and
- cannot be restored to function;
- 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 the replacement of teeth up to the normal complement of 32.

EXCLUSIONS

Benefits will not be paid for:

- 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;
- 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 CompDent Insurance Company;
- any chewing injury. A chewing injury means an injury which occurs during the act of chewing or biting. The injury may be caused by biting on a foreign object not expected to be a normal constituent of food; by parafunctional habits, such as chewing on eyeglass frames or pencils; or by biting down on a suddenly dislodged or loose dental prosthesis.
- crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
- appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;
- 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;

- 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;
- charges for travel time; transportation costs; or professional advice given on the phone;
- procedures performed by a Dentist who is a member of Your immediate family;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;
- charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
- 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;
- 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;
- the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
- treatment for cosmetic purposes; however, if the charges are made for the treatment of: (a) injuries sustained in an accident which happens while the patient is insured for Dental Benefits under this policy; or (b) congenital defects of a child born while his or her parent is insured, they will not be excluded if they qualify as Covered Dental Expenses. Facings on crowns or bridge units on molar teeth will always be considered cosmetic;
- 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;
- 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;
- a sickness for which the patient can receive benefits under a workers' compensation act or similar law;
- an injury that arises out of or in the course of a job or employment for pay or profit; or
- charges to the extent that they are more than the Prevailing Fee. If the amount of the Prevailing Fee for a service cannot be determined due to the unusual nature of the service, CompBenefits Insurance Company will determine the amount. CompBenefits Insurance Company will take into account (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors.

PREDETERMINATION

If Covered Dental Expenses for a procedure are expected to be more than \$300 it is recommended that you send a Dental Treatment Plan in prior to beginning treatment, send preauthorization to CompBenefits, P.O. Box 8236 Chicago, IL 60680-8236. You and/or your dentist will be notified of the benefits payable based upon the Dental Treatment Plan.

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

CompBenefits Family of Companies

CompDent • CompDent Insurance Company • American Dental Plan, Inc. • Oral Health Services, Inc. American Prepaid Dental Plan • American Dental Plan of North Carolina, Inc. • Vision Care, Inc.