MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

PROVIDER OF DENTAL SERVICES

Selection Criteria

The selection criteria to be used by the Fund's Contracts Committee in making its recommendation to the Fund Commissioners as to which proposal is most advantageous to the Fund, price and other factors considered, shall include:

1. The name and qualifications of the individual(s) who will perform the services;
2. Experience and reputation in the field of dental insurance;
3. Ability to perform the required services in a timely manner (including familiarity with the subject matter, attendance at meetings, etc.)
4. Competitiveness of rates (fees and expenses); and
5. Other factors, if determined to be in the best interests of the Fund.

If, after receipt of any proposals as described above and prior to any recommendation to the Fund Commissioners, the Contracts Committee determines to revise the required services or to seek more favorable terms, all vendors who have submitted proposals shall be given an equal opportunity to resubmit or modify their proposal.

Applicants will be eliminated from competition if they do not meet applicable Federal, State or County legal requirements. Where Federal or State law regulations require a procedural step(s) at variance with these procedures, the Federal or State requirements shall govern.

All contracts pursuant to the fair and open process will be awarded by a majority vote of the Fund Commissioners at a public meeting.

The term and services for which proposals are sought:

DENTAL PROGRAM

TERM. January 1, 2018 through December 31, 2020

OVERVIEW

The Middlesex County Joint Health Insurance Fund provides a Group Dental Insurance Program consisting of two distinct plan options for employees of Middlesex County and Middlesex County Board of Social Services.

Plan 1 is a Traditional PPO plan currently insured with Delta Dental. The fee schedule as outlined in Section D 6.0 provides limited reimbursement for all dental procedures. If a Delta Dental participating PPO provider is utilized, balance billing is limited to the Delta Dental PPO allowance. Out of Network providers may bill for the entire balance not paid due to the limited reimbursement schedule. The current fee schedule must be duplicated. Respondents are encouraged (but not required) to offer a self-funded alternative in addition to the insured option. Delta Dental claim experience is available.

The Fund is soliciting alternative plans to be offered as a Buy Up option to the current Delta Dental plan. The Schedule of Benefits for the Buy Up options are outlined in Section D 6.3 and D 6.4. The PPO network utilized for the buy up plans should be based on the current schedule of the responding insurance company, not the limited schedule currently in effect with Delta Dental.

Bid Sheet #1, Bid Sheet #1.a and Bid Sheet #1.b must be completed in their entirety. Bid Sheets may be found on pages 16 through 21 in the **Dental Plans Bid Package**.

Plan 2 is a DHMO Plan currently insured through Aetna. Please duplicate the specifications as outlined in Section D 7.0 of this RFP. Bid Sheet #2 found on page 22 of the **Dental Plans Bid Package** must be completed.

Plan 3 details a DHMO plan not currently in effect. Specifications are detailed in Section D 8.0. Bid Sheet #3 found on page 24 of the **Dental Plans Bid Package** must be completed. Respondents may offer a quotation for Plan 2, Plan 3 or both DHMO options.

Respondents may offer a quotation for Plan 1 Traditional PPO (with or without Buy Up options), Plan 2 DHMO or Plan 3 DHMO Alternative Copay Plan. Quoting all options is not a requirement.

Please contact Dave Hissey for census data and Delta Dental claim experience. Dave may be contacted at (610) 388-0600 or d.hissey@naimc.com.

D1.0 BASIC COVERAGE (Traditional PPO Plan)

The following is a schedule of procedure that shall be covered by the successful bidder for all eligible members and their families. Prospective bidders shall compute their Bid Price based on the schedules as shown for the Traditional PPO.

1. Initial and periodic oral examination inclusive of treatment required. Radiographs (a full-mouth radiograph shall be limited to once every three years).
2. Oral Prophylaxis including scaling and polishing.
3. Topical application of fluoride (for eligible individuals who have not yet reached their 19th birthday).
3. Repair of dentures.
4. Amalgam and synthetic restorations.
5. Emergency treatment.
6. Simple and multiple extractions.
7. Endodontic Services (pulpotomy, pulp, capping, root canal treatment).
8. Inlays and crowns not used as bridge or bridge abutment.
9. Space maintainers and/or appliances for minor tooth movement.
10. Oral surgery (surgical extractions, alveolectomy, lesion removal).
11. Apicoectomy.

D1.1 PROSTHODONTIC SERVICES – coverage shall be provided for:

1. Partial and complete dentures.
2. Bridges including crowns and inlays used as abutments or as a unit of the bridge.

SPECIAL NOTE: Benefits shall not be provided for (A) denture replacement within five years of receiving dentures under this Contract; (B) denture or bridge replacement due to the loss or theft, or (C) replacement of bridge or denture which is satisfactory or can be made satisfactory.

D 1.2 PERIODONTIC SERVICES – coverage shall be provided for:

1. Periodontic examinations.
2. Gingival Curettage: Treatment of the gums.
3. Gingivectomy, Gingio- voplasty: Gum surgery and rebuilding gums.
4. Osseous Surgery including flap entry and closure: Bone surgery.
5. Mucogingivoplastic surgery of the gums and mucous membranes.
6. Management of acute infections and oral lesions.
7. Follow-up visits with prophylaxis.

D 1.3 ELIGIBILITY

To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or condition. Services not dentally necessary are not covered benefits. The dental plan is designed to assist you in maintaining dental health. The fact that a procedure is prescribed by a dentist does not make it dentally necessary or eligible under this program. We may request proof (such as x-rays, pathology reports, or study models) to determine whether services are necessary. Failure to provide this proof may cause adjustment or denial of any procedure performed.

D 1.4 EXCLUSIONS AND LIMITATIONS

This dental plan shall not cover the following services:

- Services for injuries or conditions which are compensable under Workers Compensation Employers Liability Laws, services provided to the eligible patient by any Federal or State Government Agency, or provided without cost to the eligible patient by any municipality, county, or other political subdivision.
- Services with respect to congenital or developmental malformations (including TMJ and replacing congenitally missing teeth), cosmetic surgery, and dentistry for purely cosmetic reasons (e.g., bleaching, veneers, or crowns to improve appearance).
- Services provided in order to alter occlusion (change the bite); replace tooth structure lost by wear, abrasion, attrition, abfraction, or erosion; splint teeth; or treat or diagnose jaw joint and muscle problems (TMJ).
- Specialized or personalized services (e.g., overdentures and root canals associated with overdentures, gold foils) are excluded however, a benefit will be allowed for a conventional procedure (e.g., benefiting a conventional denture towards the cost of an overdenture and the root canals associated with it). The patient is responsible for additional costs.
- Prescribed drugs, analgesics (pain relievers), fluoride gel rinses, and preparations for home use.
- Procedures to achieve minor tooth movement.
- Experimental procedures, materials, and techniques and procedures not meeting generally accepted standards of care.
- Educational services such as nutritional or tobacco counseling for the control and prevention of oral disease. In addition, this plan shall not cover oral hygiene instruction or any equipment or supplies required.
- Services rendered by anyone who does not qualify as a fully licensed dentist. In addition, this plan shall not cover charges for hospitalization including hospital visits or broken appointments, office visits, and house calls.
- Services performed prior to effective date or after termination of coverage. Benefits are payable based on date of completion of treatment.
- Services performed for diagnosis such as laboratory tests, caries tests, bacterial studies, diagnostic casts, or photographs.
- Temporary procedures and appliances, pulp caps, occlusal adjustments, inhalation of nitrous oxide, analgesia, local anesthetic, and behavior management.
- Procedures or preparations which are part of or included in the final restoration (bases, acid etch, or micro abrasion).
- Transplants, implants, and procedures directly associated with implants including crowns and bridgework and their restoration and their maintenance or repair.
- Periodontal charting, chemical irrigation, delivery of local chemotherapeutic substances, application of desensitizing medicine, synthetic bone grafts, and guided tissue regeneration.
- Post removal (not in conjunction with root canal therapy).
- Maxillofacial surgery and prosthetic appliances.
- Completion of claim forms, providing documentation, requests for pre-determination, and services submitted for payment more than twelve (12) months following completion.
- Separate fee for infection control and OSHA compliance.

This is a general description of your dental plan to be used as a convenient reference, and some exclusions and limitations may not be listed. All benefits are governed by your group contract.

D 2.0 REPORTS

The successful vendor shall supply the Middlesex County Personnel Department with the following quarterly reports. One set of reports shall be for the County of Middlesex and one set shall be for the Board of Social Services.

1. Claims paid for traditional plan.
2. Usage history for DHMO.
3. Actual premiums paid and enrollment figures for traditional plan.
4. Actual premiums paid and enrollment figures for DHMO plan.

D 3.0 DENTAL BENEFITS SUMMARY

The Dental Benefits Summary showing the Table of Allowances shall be reviewed and approved by the Middlesex County Joint Health Insurance Fund (MCJHIF) and the MCJHIF Counsel's office prior to being mass produced and distributed.

The first draft of this booklet shall be produced by the successful vendor and submitted to the Office of the MCJHIF Executive Director/Fund Administrator within thirty (30) days of the contract inception.

D 4.0 DISCREPANCIES

Any procedure listed in these specifications that does not have a corresponding ADA procedure code shall be covered under this plan. In the event of a discrepancy, the bid specifications shall prevail.

D 5.0 BILLING

The successful vendor shall bill for services as follows:

For Middlesex County Administration and the Board of Social Services Employees:

Middlesex County Administration
Attn: Mr. Giuseppe Pruiti
County Administration Building
75 Bayard Street, 3rd. Floor New
New Brunswick, NJ 08901

D 6.0 TRADITIONAL PLAN - MINIMUM SCHEDULE OF PAYMENTS

The following is a schedule of **minimum** payments which shall be paid by the successful bidder for all eligible members and their families. The schedule of payments may be increased by the successful bidder during the life of the contract, in whole or in part. The Schedule of Payments may not be decreased by the successful bidder in whole or in part during the contract period. Prospective bidders shall compute their Bid Price based on the fee schedules as shown.

FEE SCHEDULES US DOLLARS

Diagnostic

00110 Initial oral examination	30.00
00120 Periodic oral Exam	30.00
00130 Emergency oral exam	25.00
00140 Limited oral evaluation	25.00
00150 Comprehensive oral evaluation	30.00
00160 Detailed and extensive oral exam	30.00

Radiographs

00210 Intraoral - complete series (including bitewings)	40.00
00220 Intraoral - single film	4.00
00230 Intraoral - each additional film	4.00
00270 Bitewing - single film	4.00
00272 Bitewing – two films	8.00
00273 Bitewing – three films	12.00
00274 Bitewing – four films	16.00
00280 Bitewing – each additional	4.00

Tests and Laboratory Examinations

00460 Pulp vitality tests	9.00

Preventative

01110 Prophylaxis Adults	35.00
01120 Prophylaxis Children	30.00
01201 Topical application of fluoride (including prophylaxis) -child	66.00
01203 Topical application of fluoride (excluding prophylaxis)	36.00
01510 Fixed, unilateral	150.00
01515 Fixed, bilateral	150.00
01520 Removable, unilateral	100.50
01525 Removable, bilateral	100.50

Amalgams (including polishing)

02110 Amalgam, one-surface, deciduous	35.00
02120 Amalgam, two-surface, deciduous	50.00
02130 Amalgam, three-surface, deciduous	60.00
02131 Amalgam, four-surface, deciduous	65.00
02140 Amalgam, one-surface, permanent	50.00
02150 Amalgam, two-surface, permanent	60.00
02160 Amalgam, three-surface, permanent	46.50
02161 Amalgam, four-surface, permanent	54.00

Restorations

02210 Composite resin – one surface	21.00
02310 Acrylic or plastic restoration	21.00
02330 Composite – one surface	28.50
02331 Composite resin – two surfaces	28.50
02332 Composite resin – three surfaces	28.50
02335 Composite – four or more surfaces (involving incisal angle)	28.50
02380 Composite – one surface – posterior primary	21.00
02381 Composite resin – two surfaces – posterior primary	32.00
02382 Composite resin – three surfaces – posterior primary	47.00
02385 Composite resin – one surface – posterior permanent	22.50
02386 Composite resin – two surfaces – posterior permanent	38.00
02387 Composite resin – three surfaces – posterior permanent	55.00
02510 Inlay, metallic - one surface	81.00
02520 Inlay, gold - two surfaces	117.00
02530 Inlay, three surfaces	166.50
02610 Inlay, porcelain/ceramic – one surface	120.00
02620 Inlay, porcelain/ceramic – two surfaces	120.00
02630 Inlay, porcelain/ceramic – three surfaces	120.00

Crowns - Single restoration only

02710 Plastic (acrylic) (lab)	147.00
02720 Resin with high noble metal	186.00
02721 Resin/base metal	186.00
02722 Resin/noble metal	186.00
02740 Porcelain	232.50
02750 Porcelain/high noble	229.50
02751 Porcelain/base metal	235.00
02752 Porcelain/noble metal	294.00
02780	177.00
02781	177.00
02782	177.00
02790 Gold (full cast)	199.50
02791 Gold (full cast)	199.50
02792 Gold (full cast)	199.50
02810 Gold (3/4 cast)	177.00

Other Restorative Services

02910 Replacement – inlay	15.00
02920 Replacement – crown	30.00
02930 Crown – prefabricated stainless steel primary	48.00
02931 Crown – prefabricated stainless steel permanent	48.00
02940 Sedative filling	16.50
02952 Cast post and core	64.50

Endodontic Services

03110 Pulp cap – direct (over pulp exposure)	9.00
03220 Vital pulpotomy (excluding final restoration)	28.50

Root Canal Therapy – (includes treatment plan, clinical procedure and follow-up care)

03310 Anteriors (excluded final restoration)	150.00
03320 Pre-molars (excludes final restoration)	200.00
03330 Molars (excluded final restoration)	250.00
03333 Internal root repair	84.00
03351 Apexification – initial visit	55.50
03352 Apexification –interim medical replacement	55.50
03353 Apexification – final visit	55.50

Periapcial Services

03410 Apicoectomy performed as separate surgical procedure	48.00
03421 Apicoectomy – bicuspid - first tooth	67.50
03425 Apicoectomy – molar – first tooth	67.50
03426 Apicoectomy – per tooth – each additional root	67.50
03430 Retrograde filling – per root	55.50
03450 Root amputation	84.00

Periodontics

04210 Gingivectomy or gingivoplasty per quadrant	91.50
04211 Gingivectomy or gingivoplasty – 1 tooth	19.50
04212 Gingivectomy or gingivoplasty – 2 teeth	54.90
04213 Gingivectomy or gingivoplasty – 3 teeth	54.90
04214 Gingivectomy or gingivoplasty – 4 teeth	91.50
04220 Gingival curettage	15.00
04225 Cutterage – 1 tooth	9.00
04226 Cutterage – 2 teeth	9.00
04227 Cutterage – 3 teeth	9.00
04228 Cutterage – 4 teeth	15.00
04260 Osseous surgery per quadrant	108.00
04284 Osseous surgery – 1 tooth – prorated	64.80
04285 Osseous surgery – 2 teeth – prorated	64.80
04286 Osseous surgery – 3 teeth – prorated	64.80
04287 Osseous surgery – 4 teeth – prorated	108.00
04341 Periodontal scaling and root planning (per quadrant)	15.00
04345 Scaling – gingival inflammation	32.00
04346 Scaling and root planning – 1 tooth	24.00
04347 Scaling and root planning – 2 teeth	24.00
04348 Scaling and root planning – 3 teeth	24.00
04349 Scaling and root planning – 4 teeth	40.00
04355 Full mouth debridgement for evaluation/diagnosis	32.00
04381 Delivery of chemotherapeutic agents – 1 site	28.00

04381 Delivery of chemotherapeutic agents – 2 sites	40.00
04383	7.50
04384	11.25
04910 Periodontal maintenance following active therapy	15.00

Prosthodontics, removable

05110 Complete upper	327.00
05120 Complete lower	327.00
05130 Immediate upper	367.50
05140 Immediate lower	367.50

Partial Dentures – including six-month post-delivery care

05211 Upper, without clasps, acrylic base	367.50
05212 Lower partial - acrylic base (including conventional clasps and rests)	379.50
05213 Upper partial – predominantly base cast base with acrylic saddles (including any conventional clasps and rests)	396.00
05214 Lower partial – predominantly base with cast base with acrylic saddles (including any conventional clasps and rests)	396.00
Repair to complete dentures	
05610 Repair broken complete or partial denture	39.00
05620 Repair cast framework	60.00
05640 Replace broken teeth – per tooth	15.00
05650 Add tooth to existing partial denture	28.50
05660 Partial add clasp	84.00
05730 Reline upper or lower complete denture (office)	75.00
05731 Reline lower complete	75.00
05740 Reline upper or lower partial denture (office)	75.00
05741 Reline partial lower	75.00
05750 Reline upper or lower complete denture (lab)	125.00
05751 Reline lower complete (lab)	125.00
05760 Reline upper or lower partial denture (lab)	125.00
05761 Reline lower partial (lab)	125.00

Prosthodontics, fixed

06210 Gold cast	225.00
06211 Pontic-cast/base metal	225.00
06212 Pontic-cast/noble metal	225.00
06240 Porcelain fused to gold	225.00
06241 Porcelain with base metal	225.00
06242 Porcelain with noble metal	225.00
06245 Pontic-porcelain	225.00
06250 Plastic processed to gold	225.00
06251 Pontic-resin/base metal	225.00
06252 Pontic-resin/noble metal	225.00
06720 Plastic processed to metal	225.00
06721 Plastic/nonprecious metal	225.00

06722 Resin/base metal	225.00
06750 Porcelain fused to metal	225.00
06751 Porcelain/base metal	225.00
06752 Porcelain/noble	225.00
06780 ¾ cast noble metal	225.00
06781	225.00
06782	225.00
06790 Full cast/high noble	225.00
06791 Full/base metal	225.00
06792 Full/noble metal	225.00

ORAL SURGERY

07110 Single tooth	50.00
07120 Each additional tooth	40.00
07210 Extraction of tooth, erupted	16.50
07220 Extraction of tooth, non-impacted	22.50
07230 Extraction of tooth, impacted	42.50
07240 Extraction of tooth, impacted fully bony	75.00
07250 Root recovery (surgical removal of residual root)	45.00
07285 Biopsy and examination of oral tissue (hard)	10.50
07286 Biopsy and examination of oral tissue (soft)	10.50

ALVEOPLASTY

07310 Alveoplasty in conjunction with extractions	49.50
07320 Alveoplasty not in conjunction with extractions	34.50

REMOVAL OF TUMORS, CYSTS AND NEOPLASMS

07430 Surgical excision	84.00
07431 Surgical excision	139.50
07440 Surgical excision	84.00
07441 Surgical excision	139.50
07450 Removal of cyst	55.50
07451 Removal of cyst	139.50
07460 Removal of cyst	39.00
07461 Removal of cyst	84.00

SURGICAL INCISION

07510 Incision and drainage of abscess, intraoral	27.00
07520 Incision and drainage of abscess, extraoral	55.50

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR

JOINT DYSFUNCTIONS

07810 Surgical excision – open reduction	55.50
07820 Treatment of dislocation - closed reduction	22.50

REPAIR OF TRAUMATIC WOUNDS

07910 Suture of recent small wounds, up to 5cm	27.00
07911 Suture of complicated wounds, up to 5cm	55.50
07912 Suture of complicated wounds greater than 5cm	55.50

GENERAL SERVICES

09110 Palliative (emergency treatment of dental pain, minor procedures)	25.00
09310 Consultation	15.00
09940 Occlusal guard, by report	172.50
09951 Correction of occlusion per quadrant	22.50
09952 Occlusal adjustment	22.50

D 6.1 ORTHODONTIC SERVICES

The following benefits will be afforded only to eligible members up to the end of the year they turn 23:

1. Diagnosis
2. Prophylactic appliances for tooth guidance.
3. Comprehensive orthodontic care.
4. Retaining appliances.

SPECIAL NOTE: Benefits shall be provided for active and retention treatment periods, with these maximums:

- Diagnosis (1 every five years) $50.00.
- Active Treatment including appliances 1st month $75.00; Subsequent months $35.00 Maximum of $1,300.00. Total payment upon completion of service.
- Retention Treatment (maximum 5 visits) $10.00 per visit.
- After a member receives Orthodontic services, further benefits shall only be provided if five years have elapsed since the completion of initial treatment.

D 6.2 EXCLUSIONS AND LIMITATIONS

Notwithstanding anything to the contrary in this plan, the following services are specifically excluded:

1. Any dental procedure covered under a Major Medical Plan or policy or other dental plan.
2. Services and supplies that are partially or wholly cosmetic in nature.
3. Services covered under the Workmen's Compensation, or similar law.

4. Replacement of lost, stolen, or existing prosthesis made within five years.
5. Dental procedure required by reason of insurrection, invasion, bombardment, rebellion, revolution, military or usurped power or riot.
6. Replacement of teeth by fixed bridgework where teeth are missing on both sides of the same arch or jaw. Where teeth are missing on both sides of the same arch, replacement of these missing teeth will be accomplished by removable prosthesis.
7. Expenses for duplication of any appliance to be used as a spare.
8. Expenses for appliances or restorations necessary to increase vertical dimension or restore occlusion.
9. Expenses for occlusal equilibration except to the extent necessary to treat periodontal disease.
10. Expenses for implantology.
11. Bonding procedures.
12. Treatment of unmanageable children or otherwise unruly patients. An attempt will be made to treat all patients; however, if a patient is untreatable by virtue of fear or for whatever reason or reasons, and is referred to another office for treatment, the responsibility for payment lies with either the patient or with the parents of the patient.
13. General anesthesia (sedation) other than for extractions.
14. Treatment of a patient/subscriber with a communicable disease.

D 6.3 ALTERNATIVE TRADITIONAL PPO BUY UP OPTION 1

PPO Alternative Option 1		
	In Network	Out of Network
Calendar Year Deductible		
Per Person	$50	$50
Family Aggregate Max	$100	$100
Preventive and Diagnostic		
Exams, Cleanings, Bitewing X-Rays	100%	100%
Fluoride Treatment	100%	100%
Remaining Basic		
Fillings, Extractions, Sealants		
Endodontics	80%	80%
Periodontal	80%	80%
Oral Surgery	80%	80%
Crowns & Prosthodontics		
Crowns	50%	50%
Gold Restorations	50%	50%
Bridgework	50%	50%
Full, Partial Dentures	50%	50%
Repair of Dentures	50%	50%
Calendar Year Max/Person	$2,500	$2,500
Orthodontics (Children Only)		
Coinsurance	50%	50%
Lifetime Maximum	$1,500	$1,500

D 6.4 ALTERNATIVE TRADITIONAL PPO BUY UP OPTION 2

PPO Alternative Option 2		
	In Network	Out of Network
Calendar Year Deductible		
Per Person	None	$50
Family Aggregate Max	None	$100
Preventive and Diagnostic		
Exams, Cleanings, Bitewing X-Rays	100%	100%
Fluoride Treatment	100%	100%
Remaining Basic		
Fillings, Extractions, Sealants		
Endodontics	100%	80%
Periodontal	100%	80%
Oral Surgery	100%	80%
Crowns & Prosthodontics		
Crowns	100%	50%
Gold Restorations	100%	50%
Bridgework	100%	50%
Full, Partial Dentures	100%	50%
Repair of Dentures	100%	50%
Calendar Year Max/Person	$2,500	$2,500
Orthodontics (Children Only)		
Coinsurance	100%	50%
Lifetime Maximum	$1,500	$1,500

D 7.0 DHMO PLAN

The following is a schedule of procedures that shall be covered by the successful bidder for all eligible members and their families. Prospective bidders shall compute their Bid Price based on the schedules as shown below for the DHMO.

PROCEDURE	**PATIENT COST T/F = TOTAL FEE PAID**
Diagnostic	
00110 Initial oral examination	T/F
00120 Periodic oral Exam	T/F
00130 Emergency oral exam	T/F
00140 Limited oral evaluation	T/F
00150 Comprehensive oral evaluation	T/F
00160 Detailed and extensive oral exam	T/F
Radiographs	
00210 Intraoral - complete series (including bitewings)	T/F
00220 Intraoral - single film	T/F
00230 Intraoral - each additional film	T/F
00270 Bitewing - single film	T/F
00272 Bitewing – two films	T/F
00273 Bitewing – three films	T/F
00274 Bitewing – four films	T/F
00280 Bitewing – each additional	T/F
Tests and Laboratory Examinations	
00460 Pulp vitality tests	T/F
Preventative	
01110 Prophylaxis Adults	T/F
01120 Prophylaxis Children	T/F
01201 Topical application of fluoride (including prophylaxis) - child	T/F
01203 Topical application of fluoride (excluding prophylaxis)	T/F
01510 Fixed, unilateral	T/F
01515 Fixed, bilateral	T/F
01520 Removable, unilateral	T/F
01525 Removable, bilateral	T/F
Amalgams (including polishing)	
02110 Amalgam, one-surface, deciduous	T/F
02120 Amalgam, two-surface, deciduous	T/F

PROCEDURE	**PATIENT COST** **T/F = TOTAL FEE PAID**
02130 Amalgam, three-surface, deciduous	T/F
02131 Amalgam, four-surface, deciduous	T/F
02140 Amalgam, one-surface, permanent	T/F
02150 Amalgam, two-surface, permanent	T/F
02160 Amalgam, three-surface, permanent	T/F
02161 Amalgam, four-surface, permanent	T/F
Restorations	
02210 Composite resin – one surface	T/F
02310 Acrylic or plastic restoration	T/F
02330 Composite – one surface	T/F
02331 Composite resin – two surfaces	T/F
02332 Composite resin – three surfaces	T/F
02335 Composite – four or more surfaces (involving incisal angle)	T/F
02380 Composite – one surface – posterior primary	T/F
02381 Composite resin – two surfaces – posterior primary	T/F
02382 Composite resin – three surfaces – posterior primary	T/F
02385 Composite resin – one surface – posterior permanent	T/F
02386 Composite resin – two surfaces – posterior permanent	T/F
02387 Composite resin – three surfaces – posterior permanent	T/F
02510 Inlay, metallic - one surface	T/F
02520 Inlay, gold - two surfaces	T/F
02530 Inlay, three surfaces	T/F
02610 Inlay, porcelain/ceramic – one surface	T/F
02620 Inlay, porcelain/ceramic – two surfaces	T/F
02630 Inlay, porcelain/ceramic – three surfaces	T/F
Crowns - Single restoration only	
02710 Plastic (acrylic) (lab)	T/F
02720 Resin with high noble metal	T/F
02721 Resin/base metal	T/F
02722 Resin/noble metal	T/F
02740 Porcelain	T/F
02750 Porcelain/high noble	T/F
02751 Porcelain/base metal	T/F
02752 Porcelain/noble metal	T/F
02780	T/F
02782	T/F
02790 Gold (full cast)	T/F
02791 Gold (full cast)	T/F
02792 Gold (full cast)	T/F
02810 Gold (3/4 cast)	T/F

PROCEDURE	**PATIENT COST** **T/F = TOTAL FEE PAID**
Other Restorative Services	
02910 Replacement – inlay	T/F
02920 Replacement – crown	T/F
02930 Crown – prefabricated stainless steel primary	T/F
02931 Crown – prefabricated stainless steel permanent	T/F
02940 Sedative filling	T/F
02952 Cast post and core	T/F
Endodontic Services	
03110 Pulp cap – direct (over pulp exposure)	T/F
03220 Vital pulpotomy (excluding final restoration)	T/F
Root Canal Therapy – (includes treatment plan, clinical procedure and follow-up care)	
03310 Anteriors (excluded final restoration)	T/F
03320 Pre-molars (excludes final restoration)	T/F
03330 Molars (excluded final restoration)	T/F
03333 Internal root repair	T/F
03351 Apexification – initial visit	T/F
03352 Apexification –interim medical replacement	T/F
03352 Apexification – final visit	T/F
Periapcial Services	
03410 Apicoectomy performed as separate surgical procedure	T/F
03421 Apicoectomy – bicuspid - first tooth	T/F
03425 Apicoectomy – molar – first tooth	T/F
03426 Apicoectomy – per tooth – each additional root	T/F
03430 Retrograde filling – per root	T/F
03450 Root Amputation	T/F
Periodontics	
04210 Gingivectomy or gingivoplasty per quadrant	T/F
04211 Gingivectomy or gingivoplasty – 1 tooth	T/F
04212 Gingivectomy or gingivoplasty – 2 teeth	T/F
04213 Gingivectomy or gingivoplasty – 3 teeth	T/F
04214 Gingivectomy or gingivoplasty – 4 teeth	T/F
04220 Gingival curettage	T/F
04225 Cutterage – 1 tooth	T/F
04226 Cutterage – 2 teeth	T/F
04227 Cutterage – 3 teeth	T/F

PROCEDURE	**PATIENT COST** **T/F = TOTAL FEE PAID**
04228 Cutterage – 4 teeth	T/F
04260 Osseous surgery per quadrant	T/F
04284 Osseous surgery – 1 tooth – prorated	T/F
04285 Osseous surgery – 2 teeth – prorated	T/F
04286 Osseous surgery – 3 teeth – prorated	T/F
04287 Osseous surgery – 4 teeth – prorated	T/F
04341 Periodontal scaling and root planning (per quadrant)	T/F
04345 Scaling – gingival inflammation	T/F
04346 Scaling and root planning – 1 tooth	T/F
04347 Scaling and root planning – 2 teeth	T/F
04348 Scaling and root planning – 3 teeth	T/F
04349 Scaling and root planning – 4 teeth	T/F
04355 Full mouth debridgement for evaluation/diagnosis	T/F
04381 Delivery of chemotherapeutic agents – 1 site	T/F
04381 Delivery of chemotherapeutic agents – 2 sites	T/F
04383	T/F
04384	T/F
04910 Periodontal maintenance following active therapy	T/F
Prosthodontics, removable	
05110 Complete upper	T/F
05120 Complete lower	T/F
05130 Immediate upper	T/F
05140 Immediate lower	T/F
Partial Dentures – including six-month post-delivery care	
05211 Upper, without clasps, acrylic base	T/F
05212 Lower partial - acrylic base (including conventional clasps and rests)	T/F
05213 Upper partial – predominantly base cast base with acrylic saddles (including any conventional clasps and rests)	T/F
05214 Lower partial – predominantly base with cast base with acrylic saddles (including any conventional clasps and rests)	T/F
Repair to complete dentures	
05610 Repair broken complete or partial denture	T/F
05620 Repair cast framework	T/F
05640 Replace broken teeth – per tooth	T/F
05650 Add tooth to existing partial denture	T/F
05660 Partial add clasp	T/F
05730 Reline upper or lower complete denture (office)	T/F
05731 Reline lower complete	T/F
05740 Reline upper or lower partial denture (office)	T/F
05741 Reline partial lower	T/F

PROCEDURE	**PATIENT COST** **T/F = TOTAL FEE PAID**
05750 Reline upper or lower complete denture (lab)	T/F
05751 Reline lower complete (lab)	T/F
05760 Reline upper or lower partial denture (lab)	T/F
05761 Reline lower partial (lab)	T/F
Prosthodontics, fixed	
06210 Gold cast T/F	T/F
06211 Pontic-cast/base metal	T/F
06212 Pontic-cast/noble metal	T/F
06240 Porcelain fused to gold	T/F
06241 Porcelain with base metal	T/F
06242 Porcelain with noble metal	T/F
06245 Pontic-porcelain	T/F
06250 Plastic processed to gold	T/F
06251 Pontic-resin/base metal	T/F
06252 Pontic-resin/noble metal	T/F
06720 Plastic processed to metal	T/F
06721 Plastic/nonprecious metal	T/F
06722 Resin/base metal	T/F
06750 Porcelain fused to metal	T/F
06751 Porcelain/base metal	T/F
06752 Porcelain/noble	T/F
06780 ¾ cast noble metal	T/F
06781	T/F
06782	T/F
06790 Full cast/high noble	T/F
06791 Full/base metal	T/F
06792 Full/noble metal	T/F
ORAL SURGERY	
07110 Single tooth	T/F
07120 Each additional tooth	T/F
07210 Extraction of tooth, erupted	T/F
07220 Extraction of tooth, non-impacted	T/F
07230 Extraction of tooth, impacted	T/F
07240 Extraction of tooth, impacted fully bony	T/F
07250 Root recovery (surgical removal of residual root)	T/F
07285 Biopsy and examination of oral tissue (hard)	T/F
07286 Biopsy and examination of oral tissue (soft)	T/F
General Anesthesia	$50.00
ALVEOPLASTY	
07310 Alveoplasty in conjunction with extractions	T/F

PROCEDURE	**PATIENT COST** **T/F = TOTAL FEE PAID**
07320 Alveoplasty not in conjunction with extractions	T/F
REMOVAL OF TUMORS, CYSTS AND NEOPLASMS	
07430 Surgical excision	T/F
07431 Surgical excision	T/F
07440 Surgical excision	T/F
07441 Surgical excision	T/F
07450 Removal of cyst	T/F
07451 Removal of cyst	T/F
07460 Removal of cyst	T/F
07461 Removal of cyst	T/F
SURGICAL INCISION	
07510 Incision and drainage of abscess, intraoral	T/F
07520 Incision and drainage of abscess, extraoral	T/F
REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR	
JOINT DYSFUNCTIONS	
07810 Surgical excision – open reduction	T/F
07820 Treatment of dislocation - closed reduction	T/F
REPAIR OF TRAUMATIC WOUNDS	
07910 Suture of recent small wounds, up to 5cm	T/F
07911 Suture of complicated wounds, up to 5cm	T/F
07912 Suture of complicated wounds greater than 5cm	T/F
GENERAL SERVICES	
09110 Palliative (emergency treatment of dental pain, minor procedures)	T/F
09310 Consultation	T/F
09940 Occlusal guard, by report	T/F
D 8.1 ORTHODONTIC SERVICES	
Maximum-24 months (To Age 19)	$ 500.00
Adult (19 year or older)	$1,250.00

D 8.0 DHMO – ALTERNATIVE COPAY PLAN

The following is a schedule of procedures that shall be covered by the successful bidder for all eligible members and their families for the DHMO alternative plan. Prospective bidders shall compute their Bid Price based on the schedules shown below.

PROCEDURE	**PATIENT COST** **T/F = TOTAL FEE PAID**
A. PREVENTIVE & DIAGNOSTICS	
• Office visits for observation – no other services performed	No Charge
• Oral examinations	No Charge
• Emergency palliative treatment	No Charge
• Prophylaxis, treatment to include scaling and polishing	No Charge
• Topical application of fluoride - to age 19 only	No Charge
• Study models	No Charge
• Oral hygiene instruction	Not Covered
• Sealants	Not Covered
B. X-RAYS	
• Bitewing X-rays (limit - not more than 1 series of 4 films in any six-month period)	No Charge
• Entire mouth series/Panoramic (limit - once every 3 years)	No Charge
• Periapical X-rays	No Charge
• Intra-oral, occlusal view, maxillary or mandibular	No Charge
• Extra-oral, maxillary or mandibular	No Charge
C. ENDODONTICS - Includes local anesthetics and post-operative care where necessary.	
• Root Amputation	No Charge
• Pulp vitality test	No Charge
• Pulp capping	No Charge
• Pulpotomy	No Charge
• Vital Pulpotomy	No Charge
• Temporary filling	No Charge
• Root canal therapy, including necessary X-rays and cultures but excluding complex molar cases approved as Specialty Services	
Single root canal therapy	No Charge
Bi-root canal therapy	No Charge
Tri-root canal therapy	No Charge
• Apicoectomy and filling canal	No Charge
• Apicoectomy - separate appointment	No Charge

PROCEDURE	**PATIENT COST** **T/F = TOTAL FEE PAID**

D. RESTORATIONS AND REPAIRS - Includes local anesthetics where necessary.

• Amalgam restorations (Primary Teeth)	
1 surface	No Charge
2 surfaces	No Charge
3 or more surfaces	No Charge
• Amalgam restorations (Permanent Teeth)	
1 surface	No Charge
2 surfaces	No Charge
3 or more surfaces	No Charge
• Composite, Acrylic, Plastic Restorations	
Composite Cement Filling	No Charge
Acrylic or Plastic Filling	No Charge
• Retention pins	Not Covered
• Stainless steel crowns	$50 Copayment
• Recementing inlays, crowns, bridges, space maintainers	No Charge

E. PERIODONTICS - Includes local anesthetics and post-operative care where necessary.

• Emergency treatment (abscess, acute periodontitis, etc.)	No Charge
• Subgingival curettage, per quadrant	No Charge
• Gingivectomy, per quadrant	No Charge
• Gingivectomy, per tooth (if fewer than 6 teeth)	No Charge
• Scaling and root planning (entire mouth)	No Charge
• Scaling and root planning (per quadrant)	No Charge
• Preventive Periodontal Procedures	No Charge
• Osseous Surgery	No Charge

F. ORAL SURGERY - Includes local anesthetics and post-operative care where necessary.

• Extractions, uncomplicated	No Charge
• Surgical removal of erupted tooth	No Charge
• Removal of tooth (soft tissue)	No Charge
• Removal of tooth (partial bony)	No Charge
• Removal of tooth (completely bony)	No Charge
• Excision of hyperplastic tissue	No Charge
• Excision of pericoronal gingiva	No Charge
• Incision and drainage of abscess (intra & extraoral)	No Charge

PROCEDURE	PATIENT COST T/F = TOTAL FEE PAID
• Crown exposure to aid eruption	No Charge
• Removal of foreign body from soft tissue	No Charge
• Suture of soft tissue injury	No Charge
• Post Operative visits (sutures)	No Charge

G. RESTORATIONS - Includes local anesthetics where necessary.

• Porcelain/metallic/ceramic/composite resin inlays	
1 surface	Not Covered
2 surfaces	Not Covered
• Porcelain/metallic/ceramic/composite resin onlays	
1 surface	Not Covered
2 surfaces	Not Covered
• Crowns	
Acrylic	$75 Copayment
Acrylic with metal	$230 Copayment
Porcelain	$220 Copayment
Porcelain with metal	$240 Copayment
Full metal crown	$240 Copayment
Gold onlay or 3/4 crown	$230 Copayment
Stainless steel (primary)	$50 Copayment
Stainless steel (permanent	$50 Copayment
• Post and core	Not Covered
• Pontics	
Tru-pontic type	$240 Copayment
Porcelain to metal	$240 Copayment
Plastic processed to gold	$230 Copayment
• Dentures	
Complete upper denture	$250 Copayment
Complete lower denture	$270 Copayment
• Stress Breakers (per unit)	Not Covered
• Stayplates	Not Covered
• Crown and bridge repairs	No Charge
• Adding teeth to an existing partial or denture	$30 Copayment
• Full and partial denture repairs	$20 Copayment
• Office relining/rebasing dentures	$55 Copayment
• Laboratory relining/rebasing dentures	$75 Copayment
• Habit appliances (bruxism, etc.)	Not Covered

PROCEDURE	**PATIENT COST** **T/F = TOTAL FEE PAID**

H. SPACE MAINTAINERS - Includes all adjustments within 6 months after insertion

• Fixed Spacer, Band Type	No Charge
• Removable acrylic space maintainer	No Charge

I. OTHER

• Failure to cancel appointment (24 hours prior notification)	$25 Copayment
• Emergency visit after normal visiting hours	$25 Copayment

1. SCHEDULE OF SPECIALTY DENTAL SERVICES

SPECIALTY SERVICES

A. ENDODONTICS - Includes local anesthetics and post-operative care where necessary.

• Complex Molar Root Canal Therapy (including X-rays and cultures but excluding final restoration)	No Charge
• Apicoectomy (separate procedure) - first tooth	No Charge
• Apicoectomy (separate procedure) - each additional root	No Charge
• Apicoectomy (in conjunction with endo per root)	No Charge
• Retrograde Filling	No Charge
• Root Amputation	No Charge
• Hemisection	No Charge

B. ORAL SURGERY - Includes local anesthetics and post-operative care where necessary.

• Root recovery	No Charge
• Removal of odontogenic cyst	No Charge
• Removal of nonodontogenic cyst	No Charge
• Closure of oral fistula	No Charge
• Surgical exposure of impacted or unerupted tooth for ortho reasons	No Charge
• Surgical exposure of impacted or unerupted tooth	No Charge
• Biopsy of oral tissue - hard	No Charge
• Biopsy of oral tissue - soft	No Charge
• Plastic surgery, per arch - uncomplicated	No Charge
• Plastic surgery, per arch - complicated	No Charge
• Excision of tumors - benign or malignant, any size	No Charge

PROCEDURE	**PATIENT COST** **T/F = TOTAL FEE PAID**
• Destruction of lesions by physical methods; electrosurgery, chemotherapy, cryotherapy	No Charge
• Sequestrectomy	No Charge
• Frenectomy	No Charge
• Transplantation of tooth or tooth bud	Not Covered
• Removal of exostosis (maxillary and mandibular)	No Charge
• Sialolithotomy; removal of salivary calculus	No Charge
• Surgical removal of impacted tooth	
• Partially bony	No Charge
• Completely bony	No Charge
• Removal of overgrowth of bone - upper or lower	No Charge
• Partial ostectomy (guttering or saucerization)	No Charge
• Radical removal, of mandible with bone graft	No Charge
• Incision and drainage of abscess-intraoral	No Charge
• Incision and drainage of abscess-extraoral	No Charge
• Removal of foreign body, skin or subcutaneous alveolar tissue	No Charge
• Removal of reaction -producing foreign bodies-musculoskeletal	
• system	No Charge
• Removal of dead bone	No Charge
• Maxillary sinusotomy for removal of tooth fragment or foreign body	No Charge
• Excision of hyperplastic tissue (per arch)	No Charge
• Replacement of salivary duct	No Charge

C. PERIODONTICS - Includes local anesthetics and post-operative care where necessary.

• Periodontal scaling (per quadrant)	No Charge
• Periodontal scaling (entire mouth)	No Charge
• Osseous graft	No Charge
• Osseous grafts - multiple sites	No Charge
• Pedicle soft tissue graft	No Charge
• Free soft tissue graft	No Charge
• Occlusal adjustment (other than with an appliance or by restoration)	
Limited	Not Covered
Entire mouth	Not Covered
• Osseous surgery (bone surgery) including and post-operative care and flap entry and closure, per quadrant	No Charge
• Guided Tissue Regeneration (GTR) including related procedures	Not Covered

PROCEDURE	PATIENT COST T/F = TOTAL FEE PAID
D. GENERAL ANESTHESIA	No Charge
E. ORTHODONTIC PROCEDURES	
• Orthodontic appliances and treatment - Child Only	$1,000 Copayment