

ADA Code Service Member Copayment

Office Visit Charge (per visit) 10.00
Failed (no show) appointment w/o 24 hr. notice 40.00
**Patient is responsible for the cost of any laboratory charges.*

Diagnostic and Preventive Services

120	Periodic oral evaluation	5.00
140	Limited oral evaluation - problem focused	5.00
150	Comprehensive oral evaluation - new or established patient	8.00
180	Comprehensive periodontal evaluation - new or established patient	20.00
210	Intraoral - complete series (including bitewings) (Full mouth x-rays - once every three years or as determined necessary by your dentist.)	20.00
220	Intraoral - periapical first film	4.00
230	Intraoral - periapical each additional film	2.00
240	Intraoral - occlusal film	6.00
250	Extraoral - first film	6.00
260	Extraoral - each additional film	4.00
270	Bitewing - single film	5.00
272	Bitewings - two films	7.00
274	Bitewings - four films	10.00
330	Panoramic film	25.00
460	Pulp vitality tests	None
470	Diagnostic casts	5.00

Dental Prophylaxis (cleaning) Maximum of two per contract year:

1110	Prophylaxis - adult	20.00
1120	Prophylaxis - child	18.00
1201	Topical application of fluoride (including prophylaxis) - child	20.00
1203	Topical application of fluoride (prophylaxis not included) - child	5.00
1204	Topical application of fluoride (prophylaxis not included) - adult	5.00
1205	Topical application of fluoride (including prophylaxis) - adult	22.00
1330	Oral hygiene instructions	None
1351	Sealant - per tooth	10.00

Space Maintenance:

1510	Space maintainer - fixed - unilateral	125.00
1515	Space maintainer - fixed - bilateral	150.00
1520	Space maintainer - removable - unilateral	125.00
1525	Space maintainer - removable - bilateral	150.00

Restoration Services

Amalgam Restorations:

2140	Amalgam - one surface, primary or permanent	40.00
2150	Amalgam - two surfaces, primary or permanent	45.00
2160	Amalgam - three surfaces, primary or permanent	55.00
2161	Amalgam - four or more surfaces, primary or permanent	70.00

Resin-based Composite Restorations:

2330	Resin-based composite - one surface, anterior	57.00
2331	Resin-based composite - two surfaces, anterior	67.00
2332	Resin-based composite - three surfaces, anterior	77.00
2335	Resin-based composite - four or more surfaces, or involving incisal angle (anterior)	87.00
2391	Resin-based composite - one surface, posterior	70.00
2392	Resin-based composite - two surfaces, posterior	85.00
2393	Resin-based composite - three surfaces, posterior	100.00
2394	Resin-based composite - four or more surfaces, posterior	115.00

Inlay/onlay Restorations:

2510	Inlay - metallic - one surface	320.00*
2520	Inlay - metallic - two surfaces	360.00*
2530	Inlay - metallic - three or more surfaces	390.00*
2542	Onlay - metallic - two surfaces	360.00*
2543	Onlay - metallic - three surfaces	390.00*

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2544	Onlay - metallic - four or more surfaces	390.00*
2610	Inlay - porcelain/ceramic - one surface	320.00*
2620	Inlay - porcelain/ceramic - two surfaces	360.00*
2630	Inlay - porcelain/ceramic - three or more surfaces	390.00*
2642	Onlay - porcelain/ceramic - two surfaces	360.00*
2643	Onlay - porcelain/ceramic - three surfaces	390.00*
2644	Onlay - porcelain/ceramic - four or more surfaces	390.00*
2650	Inlay - resin-based composite - one surface	320.00*
2651	Inlay - resin-based composite - two surfaces	360.00*
2652	Inlay - resin-based composite - three or more surfaces	390.00*
2662	Onlay - resin-based composite - two surfaces	360.00*
2663	Onlay - resin-based composite - three surfaces	390.00*
2664	Onlay - resin-based composite - four or more surfaces	390.00*

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Crowns - Single Restoration Only:

2710	Crown - resin (indirect)	240.00
2740	Crown - porcelain/ceramic substrate	400.00*
2750	Crown - porcelain fused to high noble metal	400.00*
2751	Crown - porcelain fused to predominantly base metal	400.00*
2752	Crown - porcelain fused to noble metal	400.00*
2780	Crown - 3/4 cast high noble metal	400.00*
2781	Crown - 3/4 cast predominantly base metal	400.00*
2782	Crown - 3/4 cast noble metal	400.00*
2783	Crown - 3/4 porcelain/ceramic	400.00*
2790	Crown - full cast high noble metal	400.00*
2791	Crown - full cast predominantly base metal	400.00*
2792	Crown - full cast noble metal	400.00*

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Other Restorative Services:

2910	Recement inlay	15.00
2920	Recement crown	15.00
2930	Prefabricated stainless steel crown - primary tooth	60.00
2931	Prefabricated stainless steel crown - permanent tooth	110.00
2932	Prefabricated resin crown	110.00
2940	Sedative filling	30.00
2950	Core buildup, including any pins	95.00
2951	Pin retention - per tooth, in addition to restoration	35.00
2952	Cast post and core in addition to crown	100.00*
2954	Prefabricated post and core in addition to crown	100.00

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Endodontics:

3110	Pulp cap - direct (excluding final restoration)	35.00
3220	Therapeutic pulpotomy (excluding final restoration)	55.00
3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	80.00
3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	80.00

Endodontic Therapy (root canal therapy):

3310	Anterior (excluding final restoration)	275.00
3320	Bicuspid (excluding final restoration)	330.00
3330	Molar (excluding final restoration)	490.00

Periodontal Surgery:

4210	Gingivectomy or Gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	225.00
4211	Gingivectomy or Gingivoplasty - one to three teeth, per quadrant	80.00

Non-Surgical Periodontal Services:

4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant (not 1110, limit 2 per visit)	85.00
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4342	Periodontal scaling and root planing - one to three teeth, per quadrant	45.00
4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	55.00
4910	Periodontal maintenance	50.00

Dentures: (When performed by your general dentist)

Full/partial dentures (upper and/or lower) - one per five year period. Replacement will be provided where casing is unsatisfactory and cannot be made satisfactory. Lost or stolen appliances are the responsibility of the patient. Unilateral partials (Nesbitt) are not a recommended treatment.

5110	Complete denture - upper	425.00*
5120	Complete denture - lower	425.00*
5130	Immediate denture - upper	440.00*
5140	Immediate denture - lower	440.00*
5211	Upper partial denture - resin base (including any conventional clasps, rests and teeth and 6 month adjustments)	450.00*
5212	Lower partial denture - resin base (including any conventional clasps, rests and teeth and 6 month adjustments)	450.00*
5213	Upper partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	500.00*
5214	Lower partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	500.00*

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Adjustments / Repairs to Dentures:

5410	Adjust complete denture - upper (after 6 months)	30.00
5411	Adjust complete denture - lower (after 6 months)	30.00
5421	Adjust partial denture - upper	30.00
5422	Adjust partial denture - lower	30.00
5510	Repair broken complete denture base	30.00*
5520	Replace missing or broken teeth - complete denture (each tooth)	30.00*
5610	Repair resin denture base	35.00*
5620	Repair cast framework	35.00*
5630	Repair or replace broken clasp	30.00*
5640	Replace broken teeth - per tooth	30.00*
5650	Add tooth to existing partial denture	30.00*
5660	Add clasp to existing partial denture	35.00*
5710	Rebase complete upper denture	225.00
5711	Rebase complete lower denture	225.00
5720	Rebase upper partial denture	225.00
5721	Rebase lower partial denture	225.00
5730	Reline complete upper denture (chairside) - one per year	125.00
5731	Reline complete lower denture (chairside) - one per year	125.00
5740	Reline upper partial denture (chairside) - one per year	125.00
5741	Reline lower partial denture (chairside) - one per year	125.00
5750	Reline complete upper denture (laboratory) - one per year	200.00
5751	Reline complete lower denture (laboratory) - one per year	200.00
5760	Reline upper partial denture (laboratory) - one per year	200.00
5761	Reline lower partial denture (laboratory) - one per year	200.00
5810	Interim complete denture (upper)	275.00
5811	Interim complete denture (lower)	275.00
5820	Interim partial denture (upper)	135.00
5821	Interim partial denture (lower)	135.00
5850	Tissue conditioning	40.00

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Bridges:

6210	Pontic - cast high noble metal	400.00*
6211	Pontic - cast predominantly base metal	400.00*
6212	Pontic - cast noble metal	400.00*
6240	Pontic - porcelain fused to high noble metal	400.00*
6241	Pontic - porcelain fused to predominantly base metal	400.00*
6242	Pontic - porcelain fused to noble metal	400.00*
6245	Maryland Bridge (Acid etched bridge (Maryland) is appropriate	

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	only on the anterior area.)	310.00
6600	Inlay - porcelain/ceramic, two surfaces	360.00*
6601	Inlay - porcelain/ceramic, three or more surfaces	400.00*
6602	Inlay - cast high noble metal, two surfaces	360.00*
6603	Inlay - cast high noble metal, three or more surfaces	400.00*
6604	Inlay - cast predominantly base metal, two surfaces	360.00*
6605	Inlay - cast predominantly base metal, three or more surfaces	400.00*
6606	Inlay - cast noble metal, two surfaces	360.00*
6607	Inlay - cast noble metal, three or more surfaces	400.00*
6608	Onlay - porcelain/ceramic, two surfaces	360.00*
6609	Onlay - porcelain/ceramic, three or more surfaces	400.00*
6610	Onlay - cast high noble metal, two surfaces	360.00*
6611	Onlay - cast high noble metal, three or more surfaces	400.00*
6612	Onlay - cast predominantly base metal, two surfaces	360.00*
6613	Onlay - cast predominantly base metal, three or more surfaces	400.00*
6614	Onlay - cast noble metal, two surfaces	360.00*
6615	Onlay - cast noble metal, three or more surfaces	400.00*
6750	Crown - porcelain fused to high noble metal	400.00*
6751	Crown - porcelain fused to predominantly base metal	400.00*
6752	Crown - porcelain fused to noble metal	400.00*
6780	Crown - 3/4 cast high noble metal	400.00*
6781	Crown - 3/4 cast predominantly base metal	400.00*
6782	Crown - 3/4 cast noble metal	400.00*
6783	Crown - 3/4 porcelain/ceramic	400.00*
6790	Crown - full cast high noble metal	400.00*
6791	Crown - full cast predominantly base metal	400.00*
6792	Crown - full cast noble metal	400.00*
6930	Recent fixed partial denture	30.00

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Oral Surgery:

7140	Extraction, erupted tooth or exposed root	53.00
7210	Surgical removal of erupted tooth	120.00
7220	Removal or impacted tooth - soft tissue	135.00
7230	Removal of impacted tooth - partially bony	165.00
7240	Removal of impacted tooth - completely bony	200.00
7280	Surgical access of an unerupted tooth	125.00
7310	Alveoloplasty in conjunction with extractions - per quadrant	110.00
7320	Alveoloplasty not in conjunction with extractions - per quadrant	140.00

Other Services:

9110	Palliative (emergency) treatment of dental pain - minor procedure	30.00
9215	Local anesthesia	None
9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	20.00
9440	Office visit - after regularly scheduled hours	40.00
9940	Occlusal guard, by report	175.00*

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Orthodontics:

	Consultation (paid by enrollee and credited to banding if treatment commences)	40.00
	Child/Adult conventional 24 month treatment (excluding x-rays and models, additional charges apply for more extensive treatment)	3,377.00
	Retention-functional applicant (after orthodontic treatment)	315.00

General Anesthesia

General Anesthesia is only covered for dependent children aged 7 years and under. General Anesthesia may not be offered at all participating provider offices.

D9220	Deep sedation / general anesthesia - first 30 minutes	300.00
D9221	Deep sedation / general anesthesia - each additional 15 minutes	100.00

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Cosmetic Services: All Cosmetic Services offered at a 15% discount

Specialty services are available from contracted specialists for a discount.

Covered Denturist Services & Copayments

When services are received from a licensed Dental Health Services' Denturist:

5110	Complete upper denture	525.00
5120	Complete lower denture	525.00
5130	Immediate upper denture	540.00
5140	Immediate lower denture	540.00
5213	Partial upper with chrome	575.00
5214	Partial lower with chrome	575.00
5410	Adjust complete denture - maxillary	20.00
5411	Adjust complete denture - mandibular	20.00
5421	Adjust partial denture - maxillary	20.00
5422	Adjust partial denture - mandibular	20.00
5510	Repair broken complete denture base	50.00
5520	Replace missing or broken teeth - complete denture, per tooth	50.00
5610	Broken denture - no teeth damaged	60.00
5620	Broken metal base - no teeth damaged	60.00
5630	Broken clasp, per clasp	55.00

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5640	Broken teeth, per tooth	55.00
5650	Add tooth to existing partial, per tooth	55.00
5660	Add clasp to existing partial, per tooth	85.00
5710	Rebase complete maxillary denture	195.00
5711	Rebase complete mandibular denture	195.00
5720	Rebase maxillary partial denture	195.00
5721	Rebase mandibular partial denture	195.00
5730	Reline complete maxillary denture (chairside)	110.00
5731	Reline complete mandibular denture (chairside)	110.00
5740	Reline maxillary partial denture (chairside)	110.00
5741	Reline mandibular partial denture (chairside)	110.00
5750	Reline complete maxillary denture (laboratory)	170.00
5751	Reline complete mandibular denture (laboratory)	170.00
5760	Reline maxillary partial denture (laboratory)	170.00
5761	Reline mandibular partial denture (laboratory)	170.00
5810	Interim complete denture - maxillary	270.00
5811	Interim complete denture - mandibular	270.00
5820	Interim partial denture - maxillary flipper	135.00
5821	Interim partial denture - lower stayplate	135.00
5850	Tissue conditioning	40.00
5850	Denture cleaning	5.00

Limitations & Exclusions

Limitations

- A. Authorized treatment is rendered only by your selected participating provider. Services provided by a dentist other than the enrollee's designated participating provider, except for emergency dental conditions, are not covered. (See item C. below)
- B. Limitation on the frequency and appropriateness of services:
 1. Prophylaxis (cleaning) – maximum of two per contract year.
 2. Periodontal scaling and periodontal maintenance – limited to four quadrants per six months.
 3. Full/ partial dentures (upper and /or lower) – one per five year period. Replacement of appliances that are causing pain, bleeding, swelling or are required due to additional tooth loss which cannot be restored by modification of the appliance are covered. New dentures are covered only if the existing denture cannot be made satisfactory by either a relines or repair. Lost or stolen appliances are the responsibility of the patient.
 4. Denture relines – one per year.
 5. Full-mouth x-rays – once every three years or as determined necessary by your dentist.
 6. Partial dentures are appropriate treatment when dental spaces are bilateral and can be satisfactorily restored with removable dentures.
 7. Unilateral partials (Nesbitt) are not a recommended treatment.
 8. Acid etched bridge (Maryland) is appropriate only on the anterior area.
 9. Fixed bridges are optional and restricted for patients under the age of 16 when periodontal tissue is not supportive or in the presence of bilateral spaces.
- C. Emergency dental condition – is the emergent and acute onset of a symptom or symptoms, including severe pain that would lead a prudent layperson acting reasonably to believe that dental condition exists that requires immediate, palliative care by a licensed dentist for the relief of pain, swelling or bleeding. This does not include routine, extensive or postponable treatment.
- D. The additional cost to the enrollee for laboratory charges, unless specified in the "Schedule of Covered Services and Copayments," will be charged at the provider's actual cost.
- E. Optional service (all cases in which the enrollee selects a plan of treatment that is considered unnecessary by the provider) is charged to the enrollee at fee-for-service rates.
- F. Cosmetic dentistry – services for appearance only are at a discount off of full fees. This includes the replacement of clinically acceptable amalgam fillings.

- G. Unsatisfactory patient-doctor relationship: Dental Health Services providers reserve the right to limit or deny services to an enrollee who fails to follow the prescribed course of treatment, repeatedly fails to keep appointments, fails to pay applicable copayments, is abusive to the participating provider or their staff, or obtains services by fraud or deception.
- H. Submit claims within 60 days. Dental Health Services shall not be liable to pay a claim for emergency care or for any Dental Health services authorized treatment provided by a dentist other than a participating provider unless the enrollee submits the claim to Dental Health Services within 60 days after treatment.
- I. Denturist benefit subject to existence and availability of a licensed denturist within a 30 mile radius. Enrollees may elect to travel to the nearest participating denturist for services.
- J. Third Molars (wisdom teeth) – complicated extractions of third molars are at the discretion of the general dentist and are often referred to oral surgeons (specialist).
- K. Not all participating dentists can perform all dental procedures, please verify what services your selected provider can perform for you.

Exclusions

The following are not covered by your dental plan:

- A. Services not specifically covered in the "Schedule of Covered Services and Copayments."
- B. Work in progress: Dental work in progress (non-emergency/temporary procedures started but not finished prior to the date of eligibility) is not covered. This includes crown preps prepared and temporized but not cemented, root canals in mid-treatment, prosthetic cases post final impression stage (sent to the lab), etc.. This does not include teeth slated for root canal treatment and/or canals filled during an emergency visit.
- C. Services that in the opinion of the attending dentist are not necessary for the patient's health. Extractions of non-pathologic, asymptomatic (healthy or non-symptomatic) teeth including extractions for orthodontic reasons.
- D. Implants – services for or attachments to implants.
- E. General anesthesia – including intravenous and inhalation sedation.
- F. Dispensing of drugs not normally supplied in a dental office.
- G. Any dental procedure or service rendered while a patient is hospitalized or not in the dental office.

- H. Temporomandibular joint (TMJ) disorders and related disease including myofunctional therapy. Procedures for training, treating or developing muscles in and around the jaw of the mouth (unless provided by a separate, supplemental Dental Health Services program.)
- I. Treatment for malignancies or neoplasms (tumors).
- J. Procedures or charges for services prior to the date the enrollee became eligible for benefits under this plan, or re-treatment of these procedures within one (1) year of completion or charges incurred following termination of benefits under this plan.
- K. Any dental procedure that cannot be performed in the dental office due to the general health of the enrollee.
- L. Procedures, appliances or restorations other than fillings that are necessary to alter, restore or maintain occlusion, or are necessary for full-mouth rehabilitation, e.g., i.e., night guards, occlusal adjustments.
- M. Orthognathic treatment – surgical procedures and other treatment to correct the malposition of the maxilla and/or the mandible.
- N. Congenital/developmental malformations: Procedures, appliances or restorations for correction of developmental conditions are not covered. This includes, but is not limited to: congenitally missing teeth, cleft palate, adverse growth patterns, facial deformities or skeletal abnormalities.
- O. Full Mouth Rehabilitation is not covered. Procedures requiring extensive restorative treatment involving more than 10 crowns and/or an increase or decrease of the horizontal or vertical dimension, gnathological recordings, full mouth equilibration, periodontal splinting, temporary processed functional crowns/appliances and realignment of teeth are not covered.
- P. Specialty Services requiring any referral to a specialist.