

# Dental Health Services

# Schedule of Covered Services and Copayments Plan C3v

Services when performed by a Dental Health Services general dentist

Code	Service	Copayment
	Office visit charge - per visit .....	4.00
	Failed/no-show appointment without 24-hour notice .....	20.00

## Diagnostic

0120	Periodic oral evaluation .....	None
0140	Limited oral evaluation - problem-focused .....	None
0150	Comprehensive oral evaluation - new or established patient .....	None
0160	Detailed and extensive oral evaluation - problem-focused .....	None
0170	Re-evaluation - limited, problem-focused .....	None
0180	Comprehensive periodontal evaluation .....	None
0210	Intraoral - complete series, including bitewings .....	None
0220	Intraoral - periapical, first film .....	None
0230	Intraoral - periapical, each additional film .....	None
0240	Intraoral - occlusal film .....	None
0250	Extraoral - first film .....	None
0260	Extraoral - each additional film .....	None
0270	Bitewing - single film .....	None
0272	Bitewings - two films .....	None
0274	Bitewings - four films .....	None
0277	Bitewings - vertical, seven to eight films .....	None
0330	Panoramic film .....	None
0460	Pulp vitality tests .....	None
0470	Diagnostic casts .....	5.00

## Preventive

Dental prophylaxis (teeth cleaning) includes shallow scaling and polishing - eligible every six months

1110	Prophylaxis - adult .....	None
1120	Prophylaxis - child .....	None
1201	Topical application of fluoride - with prophylaxis (child) .....	None
1203	Topical application of fluoride - without prophylaxis (child) .....	None
1204	Topical application of fluoride - without prophylaxis (adult) .....	None
1205	Topical application of fluoride - with prophylaxis (adult) .....	None
1310	Nutritional counseling for control of dental disease .....	None
1330	Oral hygiene instructions .....	None
1351	Sealant - per tooth .....	None

## Space maintainers

1510	Space maintainer - fixed, unilateral .....	12.00
1515	Space maintainer - fixed, bilateral .....	24.00
1520	Space maintainer - removable, unilateral .....	12.00
1525	Space maintainer - removable, bilateral .....	12.00
1550	Re-cementation of space maintainer .....	None

## Amalgam restorations - primary or permanent

2140	Amalgam - one surface, primary or permanent .....	None
2150	Amalgam - two surfaces, primary or permanent .....	None
2160	Amalgam - three surfaces, primary or permanent .....	None
2161	Amalgam - four or more surfaces, primary or permanent .....	None

## Resin-based composite restorations

2330	One surface, anterior .....	None
2331	Two surfaces, anterior .....	None
2332	Three surfaces, anterior .....	None
2335	Four or more surfaces, or involving incisal angle, anterior .....	None
2390	Crown, anterior .....	30.00
2391	One surface, posterior .....	30.00
2392	Two surfaces, posterior .....	50.00
2393	Three surfaces, posterior .....	70.00
2394	Four or more surfaces, posterior .....	90.00

Code Service Copayment

## Crowns - single restoration only

\* Additional charges of \$50 for noble metal, \$80 for high noble metal  
Add \$100 for porcelain on molars, \$50 for porcelain butt margin

2510	Inlay - metallic, one surface .....	*35.00
2520	Inlay - metallic, two surfaces .....	*35.00
2530	Inlay - metallic, three or more surfaces .....	*35.00
2542	Onlay - metallic, two surfaces .....	*35.00
2543	Onlay - metallic, three surfaces .....	*35.00
2544	Onlay - metallic, four or more surfaces .....	*35.00
2710	Resin-based composite - indirect .....	35.00
2712	3/4 resin-based composite - indirect .....	35.00
2720	Resin with high noble metal .....	*50.00
2721	Resin with base metal .....	50.00
2722	Resin with noble metal .....	*50.00
2740	Porcelain/ceramic .....	50.00
2750	Porcelain fused to high noble metal .....	*50.00
2751	Porcelain fused to base metal .....	50.00
2752	Porcelain fused to noble metal .....	*50.00
2780	3/4 cast high noble metal .....	*50.00
2781	3/4 cast base metal .....	50.00
2782	3/4 cast noble metal .....	*50.00
2783	3/4 porcelain/ceramic .....	100.00
2790	Full cast, high noble metal .....	*50.00
2791	Full cast, base metal .....	50.00
2792	Full cast, noble metal .....	*50.00
2794	Crown - titanium .....	50.00

## Other restorative services

2910	Recement inlay, onlay, or partial coverage restoration .....	None
2915	Recement cast or prefabricated post and core .....	None
2920	Recement crown .....	None
2930	Prefabricated stainless steel crown - primary tooth .....	10.00
2931	Prefabricated stainless steel crown - permanent tooth .....	10.00
2932	Prefabricated resin crown .....	10.00
2933	Prefabricated stainless steel crown with resin window .....	30.00
2934	Prefabricated coated stainless steel crown - primary tooth .....	30.00
2940	Sedative filling .....	None
2950	Core buildup, including any pins .....	None
2951	Pin retention - per tooth, in addition to restoration .....	None
2952	Cast post and core, in addition to crown .....	None
2953	Each additional cast post - same tooth .....	None
2954	Post and core, in addition to crown .....	None
2955	Post removal - not in conjunction with endodontic therapy .....	55.00
2957	Each additional pre-fabricated post - same tooth .....	None
2960	Labial veneer - resin laminate, chairside .....	35.00
2961	Labial veneer - resin laminate, laboratory .....	50.00
2962	Labial veneer - porcelain laminate, laboratory .....	50.00
2971	Additional procedures to construct new crown .....	25.00
2975	Coping .....	50.00

## Endodontics

3110	Pulp cap - direct, excluding final restoration .....	None
3120	Pulp cap - indirect, excluding final restoration .....	None
3220	Therapeutic pulpotomy, excluding final restoration .....	None
3221	Pulpal debridement - primary or permanent teeth .....	None
3230	Pulpal therapy - anterior, primary tooth .....	20.00
3240	Pulpal therapy - posterior, primary tooth .....	20.00

## Root canal therapy

3310	Anterior, excluding final restoration .....	20.00
3320	Bicuspid, excluding final restoration .....	20.00
3330	Molar, excluding final restoration .....	20.00

Code	Service	Copayment
3331	Treatment of root canal obstruction - non-surgical	20.00
3332	Incomplete root canal therapy - inoperable, unrestorable, or fractured tooth	20.00
3333	Internal root repair of perforation defects	20.00
3346	Retreatment of root canal therapy - anterior	70.00
3347	Retreatment of root canal therapy - posterior	120.00
3348	Retreatment of root canal therapy - molar	170.00
3351	Apexification/recalcification - initial visit	None
3352	Apexification/recalcification - interim visit	None
3353	Apexification/recalcification - final visit	None
3410	Apicoectomy - anterior	20.00
3421	Apicoectomy - bicuspid (first root)	20.00
3425	Apicoectomy - molar (first root)	20.00
3426	Apicoectomy - each additional root	20.00
3430	Retrograde filling - per root	None
3950	Canal preparation and fitting of pre-formed dowel or post	None

## Periodontics

4210	Gingivectomy/gingivoplasty - four or more contiguous teeth, or bounded teeth spaces, per quadrant	25.00
4211	Gingivectomy/gingivoplasty - one to three contiguous teeth, or bounded teeth spaces, per quadrant	None
4240	Gingival flap procedure, with root planing - four or more contiguous teeth, or bounded teeth spaces, per quadrant	300.00
4241	Gingival flap procedure, with root planing - one to three contiguous teeth, or bounded teeth spaces, per quadrant	200.00
4245	Apically positioned flap	200.00
4249	Clinical crown lengthening - hard tissue	200.00
4260	Osseous surgery - four or more contiguous teeth, or bounded teeth spaces, per quadrant	300.00
4261	Osseous surgery - one to three contiguous teeth, or bounded teeth spaces, per quadrant	200.00
4271	Free soft tissue graft procedure	275.00
4341	Scaling and root planing - four or more contiguous teeth, or bounded teeth spaces, per quadrant	None
4342	Scaling and root planing - one to three contiguous teeth, or bounded teeth spaces, per quadrant	None
4355	Full mouth debridement to enable evaluation and diagnosis	None
4381	Crevicular tissue treatment - per tooth	50.00
4910	Periodontal maintenance	None

## Dentures

Dentures and partials include four months free adjustments  
Add lab cost of any gold

5110	Complete denture - upper	65.00
5120	Complete denture - lower	65.00
5130	Immediate denture - upper	65.00
5140	Immediate denture - lower	75.00
5211	Upper partial denture - resin base, including clasps, rests, teeth	75.00
5212	Lower partial denture - resin base, including clasps, rests, teeth	75.00
5213	Upper partial denture - cast metal framework with resin denture bases, including clasps, rests, teeth	75.00
5214	Lower partial denture - cast metal framework with resin denture bases, including clasps, rests, teeth	75.00
5225	Upper partial denture - flexible base, including clasps, rests, teeth	275.00
5226	Lower partial denture - flexible base, including clasps, rests, teeth	275.00
5281	Removable unilateral partial denture - one piece cast metal, including clasps, teeth	50.00

## Denture adjustments & repairs

5410	Adjust complete denture - upper	None
5411	Adjust complete denture - lower	None
5421	Adjust partial denture - upper	None
5422	Adjust partial denture - lower	None
5510	Repair broken complete denture base	5.00
5520	Replace missing or broken teeth - per tooth	5.00
5610	Repair resin denture base	5.00
5620	Repair cast framework	5.00

Code	Service	Copayment
5630	Repair or replace broken clasp	None
5640	Replace broken teeth - per tooth	5.00
5650	Add tooth to existing partial denture	5.00
5660	Add clasp to existing partial denture	5.00
5670	Replace all teeth and acrylic on cast metal - upper	145.00
5671	Replace all teeth and acrylic on cast metal - lower	145.00
5710	Rebase complete upper denture	None
5711	Rebase complete lower denture	None
5720	Rebase partial upper denture	None
5721	Rebase partial lower denture	None
5730	Reline complete upper denture - chairside	10.00
5731	Reline complete lower denture - chairside	10.00
5740	Reline partial upper denture - chairside	10.00
5741	Reline partial lower denture - chairside	10.00
5750	Reline complete upper denture - laboratory	10.00
5751	Reline complete lower denture - laboratory	10.00
5760	Reline partial upper denture - laboratory	10.00
5761	Reline partial lower denture - laboratory	10.00
5810	Temporary complete upper denture	45.00
5811	Temporary complete lower denture	45.00
5820	Temporary partial upper denture	45.00
5821	Temporary partial lower denture	45.00
5850	Tissue conditioning - upper	20.00
5851	Tissue conditioning - lower	20.00

## Bridges

\* Additional charges of \$50 for noble metal, \$80 for high noble metal  
Add \$100 for porcelain on molars, \$50 for porcelain butt margin

6205	Pontic - indirect resin-based composite	45.00
6210	Pontic - cast high noble metal	*45.00
6211	Pontic - cast predominantly base metal	45.00
6212	Pontic - cast noble metal	*45.00
6214	Pontic - titanium	45.00
6240	Pontic - porcelain fused to high noble metal	*45.00
6241	Pontic - porcelain fused to base metal	45.00
6242	Pontic - porcelain fused to noble metal	*45.00
6245	Pontic - porcelain/ceramic	50.00
6250	Pontic - resin with high noble metal	*45.00
6251	Pontic - resin with base metal	45.00
6252	Pontic - resin with noble metal	*45.00
6545	Maryland bridge retainer, per unit	45.00
6548	Retainer - porcelain/ceramic - resin-bonded prosthesis	50.00
6600	Inlay - porcelain/ceramic, two surfaces	50.00
6601	Inlay - porcelain/ceramic, three or more surfaces	50.00
6602	Inlay - cast high noble metal, two surfaces	*35.00
6603	Inlay - cast high noble metal, three or more surfaces	*35.00
6604	Inlay - cast base metal, two surfaces	35.00
6605	Inlay - cast base metal, three or more surfaces	35.00
6606	Inlay - cast noble metal, two surfaces	*35.00
6607	Inlay - cast noble metal, three or more surfaces	*35.00
6608	Onlay - porcelain/ceramic, two surfaces	50.00
6609	Onlay - porcelain/ceramic, three or more surfaces	50.00
6610	Onlay - cast high noble metal, two surfaces	*35.00
6611	Onlay - cast high noble metal, three or more surfaces	*35.00
6612	Onlay - cast base metal, two surfaces	35.00
6613	Onlay - cast base metal, three or more surfaces	35.00
6614	Onlay - cast noble metal, two surfaces	*35.00
6615	Onlay - cast noble metal, three or more surfaces	*35.00
6624	Inlay - titanium	45.00
6634	Onlay - titanium	45.00
6710	Crown - indirect resin-based composite	35.00
6720	Crown - resin with high noble metal	*35.00
6721	Crown - resin with base metal	35.00
6722	Crown - resin with noble metal	*35.00
6740	Crown - porcelain/ceramic	50.00
6750	Crown - porcelain fused to high noble metal	*50.00
6751	Crown - porcelain fused to base metal	50.00
6752	Crown - porcelain fused to noble metal	*50.00
6780	Crown - 3/4 cast high noble metal	*50.00
6781	Crown - 3/4 cast base metal	50.00
6782	Crown - 3/4 cast noble metal	*50.00

Code	Service	Copayment
6783	Crown - 3/4 porcelain/ceramic	100.00
6790	Crown - full cast high noble metal	*50.00
6791	Crown - full cast base metal	50.00
6792	Crown - full cast noble metal	*50.00
6794	Crown - titanium	45.00
6930	Re-cement fixed partial denture	None
6970	Cast post and core	*None
6971	Cast post - as part of fixed partial denture retainer	None
6972	Prefabricated post and core	None
6973	Core build up for retainer - including any pins	None
6975	Coping - metal	*10.00
6976	Each additional cast post - same tooth	None
6977	Each additional prefabricated post - same tooth	None

### Oral surgery

7111	Extraction - coronal remnants, deciduous tooth	None
7140	Extraction - erupted tooth or exposed root	None
7210	Surgical removal of erupted tooth	5.00
7220	Removal of impacted tooth - soft tissue	15.00
7230	Removal of impacted tooth - partially bony	40.00
7240	Removal of impacted tooth - completely bony	40.00
7241	Removal of impacted tooth with unusual surgical conditions	90.00
7250	Surgical removal of residual tooth roots	5.00
7270	Tooth reimplantation and/or stabilization	50.00
7282	Mobilization of erupted or malpositioned tooth	5.00
7310	Alveoloplasty with extractions, per quadrant	None
7311	Alveoloplasty with extractions - one to three teeth, or teeth spaces, per quadrant	None
7320	Alveoloplasty not with extractions, per quadrant	None
7321	Alveoloplasty not with extractions - one to three teeth, or teeth spaces, per quadrant	None
7510	Incision and drainage of abscess	None
7511	Incision and drainage of abscess - complicated	50.00

### Dental exclusions

The following services are not covered by your dental plan

- Services that are not consistent with professionally recognized standards of practice.
- Services related to implants or attachments to implants.
- Cosmetic services, for appearance only, unless specifically listed.
- Myofunctional therapy-procedures for training, treating or developing muscles in and around the jaw or mouth including T.M.J. and related diseases, except for occlusal guard.
- Treatment for malignancies, neoplasms (tumors) and cysts as well as hereditary, congenital and/or developmental malformations.
- Dispensing of drugs not normally supplied in a dental office.
- Hospitalization charges, dental procedures or services rendered while patient is hospitalized.
- Procedures, appliances or restorations (other than fillings) that are necessary for full mouth rehabilitation, to increase arch vertical dimension, or crown/bridgework requiring more than 10 crowns/pontics. Replacement or stabilization of tooth structure lost through attrition, abrasion or erosion. Procedures performed by a prosthodontist.
- Fixed bridges for patients under the age of sixteen, in the presence of non-supportive periodontal tissue, when edentulous spaces are bilateral in the same arch, when replacement of more than four teeth in an arch, replacement of missing third molars, or when the prognosis is poor.
- General anesthesia, including intravenous and inhalation sedation.
- Dental procedures that cannot be performed in the dental office due to the general health and/or physical limitations of the member.

Code	Service	Copayment
9110	Emergency treatment - minor procedure	25.00
9215	Local anesthesia	None
9310	Second opinion consultation	20.00
9440	Office visit - after regularly scheduled hours	25.00
9450	Case presentation - detailed	None
9630	Other medicaments, intra-sulcular irrigation	25.00
9910	Root desensitizing	5.00
9911	Cervical/root desensitizing, per tooth	5.00
9940	Occlusal guard - by report	120.00
9941	Fabrication of athletic mouthguard	60.00
9942	Repair and/or relining of occlusal guard	60.00
9971	Odontoplasty - one or two teeth	5.00
9974	Internal bleaching - per tooth	100.00

### Services when performed by a Dental Health Services orthodontist

Please call your Member Service specialist at 800.63.SMILE for a referral to the nearest participating orthodontist

### Orthodontics

Consultation	25.00
Failed/no-show appointment without 24-hour notice	25.00
Full banded - child, up to age 19	1775.00
Full banded - adult	1975.00
Partial banded - child, up to age 19	1250.00
Partial banded - adult	1450.00
Mixed dentition - phase I	450.00
Palatal expansion	350.00
Rapid palatal expansion	550.00
Retention appliance - after orthodontic treatment	180.00
Functional appliance (Bionator-Frankel)	550.00
Headgear	350.00
Simple crossbite	275.00
Copying records	40.00

- Expenses incurred for dental procedures initiated prior to member's eligibility with Dental Health Services, or after termination of eligibility.
- Services that are reimbursed by a third party (such as the medical portion of an insurance/health plan or any other third party indemnification).
- Extractions of non-pathologic, asymptomatic teeth, including extractions and/or surgical procedures for orthodontic reasons.
- Setting of a fracture or dislocation, surgical procedures related to cleft palate, micrognathia or macrognathia, and surgical grafting procedures.
- Coordination of benefits with another prepaid managed care dental plan.
- Orthodontic treatment of a case in progress and/or retreatment of orthodontic cases.
- Cephalometric x-rays, tracings, photographs and orthodontic study models.
- Replacement of lost or broken orthodontic appliances.
- Changes in orthodontic treatment necessitated by an accident of any kind.
- Malocclusions so severe or mutilated which are not amenable to ideal orthodontic therapy.
- Services not specifically covered on the Schedule of Covered Services and Copayments.

### Dental limitations

Restrictions on benefits are applied to the following services

- Treatment of dental emergencies is limited to treatment that will alleviate acute symptoms and does not cover definitive restorative treatment including, but not limited to root canal treatment and crowns.

- B. Optional services: when the patient selects a plan of treatment that is considered optional or unnecessary by the attending dentist, the additional cost is the responsibility of the patient.
- C. Routine teeth cleaning (prophylaxis) is limited to once every six months and full mouth x-rays are limited to one set every three years if needed.
- D. Sealants are only a benefit for permanent posterior teeth of children under the age of eighteen.
- E. Covered specialist referrals must be pre-approved by Dental Health Services.
- F. Periodontal surgical procedures are limited to four quadrants every two years.
- G. There are additional charges for precious/noble metals (gold).
- H. Replacement will be made of any existing appliance (denture, etc.) only if it is unsatisfactory and cannot be made satisfactory. Prosthetic appliances will be replaced only after five years have elapsed from the time of delivery. Lost or stolen removable appliances are the responsibility of the enrollee.
- I. Relines are limited to once per twelve months, per appliance.
- J. Single unit inlays and crowns are a benefit as provided above only when the teeth cannot be adequately restored with other restorative materials.
- K. The maximum benefit for pedodontic specialty care is \$500 per lifetime.

Enrollees should refer to the Group Service Agreement for further information on benefit exclusions and limitations.

### Orthodontic exclusions

- A. Retreatment of orthodontic cases.
- B. Treatment of a case in progress at inception of eligibility.
- C. Surgical procedures (including extraction of teeth) incidental orthodontic treatment.
- D. Surgical procedures related to cleft palate, micrognathia or macrognathia.
- E. Treatment related to temporomandibular joint (TMJ) disturbances and/or hormonal imbalances.

F. Any dental procedure considered within the field of general dentistry, including but not limited to: myofunctional therapy; general anesthetics, including intravenous and inhalation sedation; dental services of any nature performed in a hospital.

### Orthodontic limitations

The following are subject to additional charges

- A. Cephalometric x-rays, dental x-rays.
- B. Tracings and photographs.
- C. Study models.
- D. Replacement of lost or broken appliances.
- E. Changes in treatment necessitated by an accident of any kind.
- F. Services which are compensable under worker's compensation or employer liability laws.
- G. Malocclusions so severe or mutilated they are not amenable to ideal orthodontic therapy.
- H. Full banded treatments are based on a 24-month standard treatment plan. Additional treatment, or treatment that extends beyond that time may be subject to additional charges.

If the contract between the group and Dental Health Services is terminated, service is subject to a pro-rated fee based on current market value for the balance of orthodontic treatment. If the member should terminate group coverage, they are no longer eligible for the group orthodontic rate.

Should the contract between Dental Health Services and the orthodontist terminate, any Dental Health Services members in treatment would not be subject to proration.

Please call your Member Service specialist at 800.63.SMILE for a referral to the nearest participating orthodontist.

### Health plan benefits and coverage matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Deductibles: None

Lifetime maximums: Pedodontic specialty services have a lifetime maximum of \$500. There are no other maximums.

Professional services - exam & preventive services: No charge for most services. Full mouth x-rays limited to every three years. Prophylaxis (cleanings) limited to every six months. Sealants limited to permanent teeth to age 18.

Professional services - restorative, crowns, endodontics and oral surgery services: Copayments for fillings, caps, root canals and extractions vary by procedure in the enclosed Schedule.

Professional services - periodontic services: Copayments for gum treatments vary by procedure in the enclosed Schedule. Surgical procedures are limited to four quads every two years.

Professional services - dentures and partial dentures: Copayments vary by procedure and appear in the enclosed Schedule. Replacements limited to every five years. Relines limited to every 12 months.

Professional services - specialty services: Copayments vary by procedure and appear in the enclosed Schedule of Covered Services and Copayments.

Outpatient office visits: \$4 per visit

Hospitalization services: Not covered

Prescription drug coverage: Not covered

Emergency health services: Not covered

Ambulance services: Not covered

Durable medical equipment: Not covered

Mental health services: Not covered

Chemical dependency services: Not covered

Home health services: Not covered.

This dental plan does not provide general anesthesia. Members requiring general anesthesia should inquire with their medical plan for coverage.

These benefits can only be changed by Dental Health Services with 30 days prior notice given to the group, and with the group's consent to the proposed changes.