Dental Health Services

Schedule of Covered Services and Copayments
Super SmartSmile℠

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
1330	Oral hygiene instructions	None
1351	Sealant - per tooth	5.00

Space maintainers

1510	Space maintainer - fixed, unilateral	40.00
1515	Space maintainer - fixed, bilateral	60.00
1520	Space maintainer - removable, unilateral	30.00
1525	Space maintainer - removable, bilateral	40.00
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	20.00
2331	Two surfaces, anterior	33.00
2332	Three surfaces, anterior	46.00
2335	Four or more surfaces, or involving incisal angle, anterior	60.00
2390	Crown, anterior	35.00
2391	One surface, posterior	85.00
2392	Two surfaces, posterior	120.00
2393	Three surfaces, posterior	150.00
2394	Four or more surfaces, posterior	160.00

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. and $200 for upgraded, special, or characterized crowns such as Cercon, Empress, Captek, and Procera**

2510	Inlay - metallic, one surface	*200.00
2520	Inlay - metallic, two surfaces	*200.00
2530	Inlay - metallic, three or more surfaces	*200.00
2542	Onlay - metallic, two surfaces	*200.00
2543	Onlay - metallic, three surfaces	*200.00
2544	Onlay - metallic, four or more surfaces	*200.00
2610	Inlay - porcelain/ceramic, one surface	340.00
2620	Inlay - porcelain/ceramic, two surfaces	340.00
2630	Inlay - porcelain/ceramic, three or more surfaces	340.00
2642	Onlay - porcelain/ceramic, two surfaces	340.00
2643	Onlay - porcelain/ceramic, three surfaces	340.00
2644	Onlay - porcelain/ceramic, four or more surfaces	340.00
2650	Inlay - resin-based composite, one surface	230.00
2651	Inlay - resin-based composite, two surfaces	250.00
2652	Inlay - resin-based composite, three or more surfaces	250.00
2662	Onlay - resin-based composite, two surfaces	250.00
2663	Onlay - resin-based composite, three surfaces	250.00
2664	Onlay - resin-based composite, four or more surfaces	250.00
2710	Resin-based composite - indirect	120.00
2712	3/4 resin-based composite - indirect	120.00
2720	Resin with high noble metal	*120.00
2721	Resin with base metal	120.00
2722	Resin with noble metal	*120.00
2740	Porcelain/ceramic	240.00
2750	Porcelain fused to high noble metal	*240.00
2751	Porcelain fused to base metal	240.00
2752	Porcelain fused to noble metal	*240.00
2780	3/4 cast high noble metal	*225.00
2781	3/4 cast base metal	225.00
2782	3/4 cast noble metal	*225.00
2783	3/4 porcelain/ceramic	240.00
2790	Full cast, high noble metal	*225.00
2791	Full cast, base metal	225.00
2792	Full cast, noble metal	*225.00
2794	Crown - titanium	225.00

Other restorative services

2910	Recement inlay, onlay, or partial coverage restoration	15.00
2915	Recement cast or prefabricated post and core	15.00
2920	Recement crown	15.00
2930	Prefabricated stainless steel crown - primary tooth	50.00
2931	Prefabricated stainless steel crown - permanent tooth	50.00
2932	Prefabricated resin crown	50.00
2933	Prefabricated stainless steel crown with resin window	70.00
2934	Prefabricated coated stainless steel crown - primary tooth	70.00
2940	Sedative filling	None
2950	Core buildup, including any pins	25.00
2951	Pin retention - per tooth, in addition to restoration	20.00
2952	Cast post and core, in addition to crown	60.00
2953	Each additional cast post - same tooth	None
2954	Post and core, in addition to crown	55.00
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	220.00
2961	Labial veneer - resin laminate, laboratory	260.00
2962	Labial veneer - porcelain laminate, laboratory	340.00
2971	Additional procedures to construct new crown	25.00

Code	Service	Copayment

Endodontics

3110	Pulp cap - direct, excluding final restoration	10.00
3120	Pulp cap - indirect, excluding final restoration	4.00
3220	Therapeutic pulpotomy, excluding final restoration	15.00
3221	Pulpal debridement - primary or permanent teeth	45.00
3230	Pulpal therapy - anterior, primary tooth	45.00
3240	Pulpal therapy - posterior, primary tooth	55.00

Root canal therapy

3310	Anterior, excluding final restoration	100.00
3320	Bicuspid, excluding final restoration	175.00
3330	Molar, excluding final restoration	300.00
3331	Treatment of root canal obstruction - non-surgical	45.00
3332	Incomplete root canal therapy - inoperable, unrestorable, or fractured tooth	70.00
3333	Internal root repair of perforation defects	45.00
3346	Retreatment of root canal therapy - anterior	150.00
3347	Retreatment of root canal therapy - posterior	250.00
3348	Retreatment of root canal therapy - molar	350.00
3351	Apexification/recalcification - initial visit	30.00
3352	Apexification/recalcification - interim visit	30.00
3353	Apexification/recalcification - final visit	30.00
3410	Apicoectomy - anterior	150.00
3421	Apicoectomy - bicuspid (first root)	150.00
3425	Apicoectomy - molar (first root)	150.00
3426	Apicoectomy - each additional root	100.00
3430	Retrograde filling - per root	80.00
3950	Canal preparation and fitting of pre-formed dowel or post	55.00

Periodontics

4210	Gingivectomy/gingivoplasty - four or more contiguous teeth, or bounded teeth spaces, per quadrant	120.00
4211	Gingivectomy/gingivoplasty - one to three contiguous teeth, or bounded teeth spaces, per quadrant	50.00
4240	Gingival flap procedure, with root planing - four or more contiguous teeth, or bounded teeth spaces, per quadrant	250.00
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	250.00
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	400.00
4341	Scaling and root planing - four or more contiguous teeth, or bounded teeth spaces, per quadrant	45.00
4342	Scaling and root planing - one to three contiguous teeth, or bounded teeth space, per quadrant	30.00
4355	Full mouth debridement to enable evaluation and diagnosis	45.00
4381	Crevicular tissue treatment - per tooth	50.00
4910	Periodontal maintenance	45.00

Dentures

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

5110	Complete denture - upper	310.00
5120	Complete denture - lower	310.00
5130	Immediate denture - upper	320.00
5140	Immediate denture - lower	320.00
5211	Upper partial denture - resin base, including clasps, rests, teeth	180.00
5212	Lower partial denture - resin base, including clasps, rests, teeth	180.00
5213	Upper partial denture - cast metal framework with resin denture bases, including clasps, rests, teeth	410.00
5214	Lower partial denture - cast metal framework with resin denture bases, including clasps, rests, teeth	410.00
5225	Upper partial denture - flexible base, including clasps, rests, teeth	610.00
5226	Lower partial denture - flexible base, including clasps, rests, teeth	610.00
5281	Removable unilateral partial denture - one piece cast metal, including clasps, teeth	130.00

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	30.00
5520	Replace missing or broken teeth - per tooth	20.00
5610	Repair resin denture base	30.00
5620	Repair cast framework	50.00
5630	Repair or replace broken clasp	40.00
5640	Replace broken teeth - per tooth	20.00
5650	Add tooth to existing partial denture	20.00
5660	Add clasp to existing partial denture	30.00
5670	Replace all teeth and acrylic on cast metal - upper	220.00
5671	Replace all teeth and acrylic on cast metal - lower	220.00
5710	Rebase complete upper denture	120.00
5711	Rebase complete lower denture	120.00
5720	Rebase partial upper denture	120.00
5721	Rebase partial lower denture	120.00
5730	Reline complete upper denture - chairside	60.00
5731	Reline complete lower denture - chairside	60.00
5740	Reline partial upper denture - chairside	60.00
5741	Reline partial lower denture - chairside	60.00
5750	Reline complete upper denture - laboratory	90.00
5751	Reline complete lower denture - laboratory	90.00
5760	Reline partial upper denture - laboratory	90.00
5761	Reline partial lower denture - laboratory	90.00
5810	Temporary complete upper denture	100.00
5811	Temporary complete lower denture	100.00
5820	Temporary partial upper denture	100.00
5821	Temporary partial lower denture	100.00
5850	Tissue conditioning - upper	25.00
5851	Tissue conditioning - lower	25.00

Bridges

*** Additional charges of $50 for noble metal, $80 for high noble metal**
Add $100 for porcelain on molars, $50 for porcelain butt margin.
and $200 for upgraded, special, or characterized crowns such as
Cercon, Empress, Captek, and Procera

6205	Pontic - indirect resin-based composite	120.00
6210	Pontic - cast high noble metal	*200.00
6211	Pontic - cast predominantly base metal	225.00
6212	Pontic - cast noble metal	*225.00
6214	Pontic - titanium	225.00
6240	Pontic - porcelain fused to high noble metal	*240.00
6241	Pontic - porcelain fused to base metal	240.00
6242	Pontic - porcelain fused to noble metal	*240.00
6245	Pontic - porcelain/ceramic	240.00
6250	Pontic - resin with high noble metal	*120.00
6251	Pontic - resin with base metal	120.00
6252	Pontic - resin with noble metal	*120.00
6545	Maryland bridge retainer, per unit	170.00
6548	Retainer - porcelain/ceramic - resin-bonded prosthesis	170.00
6600	Inlay - porcelain/ceramic, two surfaces	240.00
6601	Inlay - porcelain/ceramic, three or more surfaces	240.00
6602	Inlay - cast high noble metal, two surfaces	*240.00
6603	Inlay - cast high noble metal, three or more surfaces	*240.00
6604	Inlay - cast base metal, two surfaces	230.00
6605	Inlay - cast base metal, three or more surfaces	230.00
6606	Inlay - cast noble metal, two surfaces	*230.00
6607	Inlay - cast noble metal, three or more surfaces	*230.00
6608	Onlay - porcelain/ceramic, two surfaces	230.00
6609	Onlay - porcelain/ceramic, three or more surfaces	230.00
6610	Onlay - cast high noble metal, two surfaces	*240.00
6611	Onlay - cast high noble metal, three or more surfaces	*240.00
6612	Onlay - cast base metal, two surfaces	230.00
6613	Onlay - cast base metal, three or more surfaces	230.00
6614	Onlay - cast noble metal, two surfaces	*230.00

Code	Service	Copayment
6615	Onlay - cast noble metal, three or more surfaces	*230.00
6624	Inlay - titanium	225.00
6634	Onlay - titanium	225.00
6710	Crown - indirect resin-based composite	120.00
6720	Crown - resin with high noble metal	*120.00
6721	Crown - resin with base metal	120.00
6722	Crown - resin with noble metal	*120.00
6740	Crown - porcelain/ceramic	230.00
6750	Crown - porcelain fused to high noble metal	*240.00
6751	Crown - porcelain fused to base metal	240.00
6752	Crown - porcelain fused to noble metal	*240.00
6780	Crown - 3/4 cast high noble metal	*225.00
6781	Crown - 3/4 cast base metal	225.00
6782	Crown - 3/4 cast noble metal	*225.00
6783	Crown - 3/4 porcelain/ceramic	250.00
6790	Crown - full cast high noble metal	*225.00
6791	Crown - full cast base metal	225.00
6792	Crown - full cast noble metal	*225.00
6794	Crown - titanium	225.00
6930	Re-cement fixed partial denture	20.00
6970	Cast post and core	*20.00
6971	Cast post - as part of fixed partial denture retainer	20.00
6972	Prefabricated post and core	55.00
6973	Core build up for retainer - including any pins	25.00
6975	Coping - metal	*60.00
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	30.00
7220	Removal of impacted tooth - soft tissue	50.00
7230	Removal of impacted tooth - partially bony	75.00
7240	Removal of impacted tooth - completely bony	100.00
7250	Surgical removal of residual tooth roots	120.00
7270	Tooth reimplantation and/or stabilization	200.00
7310	Alveoloplasty with extractions, per quadrant	55.00
7311	Alveoloplasty with extractions - one to three teeth, or teeth spaces, per quadrant	55.00
7320	Alveoloplasty not with extractions, per quadrant	55.00
7321	Alveoloplasty not with extractions - one to three teeth, or teeth spaces, per quadrant	55.00
7510	Incision and drainage of abscess	5.00
7511	Incision and drainage of abscess - complicated	100.00

Other services

9110	Emergency treatment - minor procedure	10.00
9215	Local anesthesia	None
9310	Second opinion consultation	None
9440	Office visit - after regularly scheduled hours	50.00
9450	Case presentation - detailed	None
9630	Other medicaments, intra-sulcular irrigation	25.00
9910	Root desensitizing	20.00
9911	Cervical/root desensitizing, per tooth	20.00
9940	Occlusal guard - by report	180.00
9941	Fabrication of athletic mouthguard	100.00
9970	Enamel microabrasion	20.00
9971	Odontoplasty - one or two teeth	20.00
9972	External bleaching - per arch	200.00
9973	External bleaching - per tooth	100.00
9974	Internal bleaching - per tooth	100.00

Services when performed by a Dental Health Services specialist

Specialty services require prior authorization by Dental Health Services. Your general dentist will determine your need for specialty care and contact Dental Health Services for this authorization. Your copayments for specialty procedures are listed below. In most cases they are higher than for services when completed by a general dentist.

Code	Service	Copayment

The maximum benefit for specialty care, excluding orthodontics, is $1,000 per member, per contract year. The benefit is the amount paid by Dental Health Services. Your contract year benefit begins on the date of your eligibility and renews on the same date the following year. Specialty services provided for one family member will not affect the limitation for another family member.

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	1975.00
	Full banded - adult	2175.00
	Partial banded - child, up to age 19	1250.00
	Partial banded - adult	1550.00
	Mixed dentition - phase I	600.00
	Palatal expansion	450.00
	Rapid palatal expansion	600.00
	Retention appliance - after orthodontic treatment	250.00
	Functional appliance (Bionator-Frankel)	600.00
	Headgear	400.00
	Simple crossbite	400.00
	Copying records	40.00

Diagnostic

0120	Periodic oral evaluation	45.00
0140	Limited oral evaluation - problem-focused	45.00
0150	Comprehensive oral evaluation - new or established patient	45.00
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	65.00
0220	Intraoral - periapical, first film	12.00
0230	Intraoral - periapical, each additional film	8.00
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	21.00
0274	Bitewings - four films	30.00
0277	Bitewings - vertical, seven to eight films	None
0330	Panoramic film	55.00

Preventive

1110	Prophylaxis - adult	30.00
1120	Prophylaxis - child	40.00
1201	Topical application of fluoride - with prophylaxis (child)	50.00
1203	Topical application of fluoride - without prophylaxis (child)	26.00
1204	Topical application of fluoride - without prophylaxis (adult)	15.00
1330	Oral hygiene instructions	None
1351	Sealant - per tooth	35.00

Space maintainers

1510	Space maintainer - fixed, unilateral	210.00
1515	Space maintainer - fixed, bilateral	290.00
1520	Space maintainer - removable, unilateral	240.00
1525	Space maintainer - removable, bilateral	300.00
1550	Re-cementation of space maintainer	48.00

Amalgam restorations - primary or permanent

2140	Amalgam - one surface, primary or permanent	60.00
2150	Amalgam - two surfaces, primary or permanent	80.00
2160	Amalgam - three surfaces, primary or permanent	95.00
2161	Amalgam - four or more surfaces, primary or permanent	115.00

Resin-based composite restorations

2330	One surface, anterior	78.00

Code	Service	Copayment
2331	Two surfaces, anterior	100.00
2332	Three surfaces, anterior	120.00
2335	Four or more surfaces, or involving incisal angle, anterior	140.00
2390	Crown, anterior	200.00
2391	One surface, posterior	85.00
2392	Two surfaces, posterior	115.00
2393	Three surfaces, posterior	143.00
2394	Four or more surfaces, posterior	175.00

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

2710	Resin-based composite - indirect	330.00
2712	3/4 resin-based composite - indirect	306.00
2720	Resin with high noble metal	*450.00
2721	Resin with base metal	450.00
2750	Porcelain fused to high noble metal	*530.00
2751	Porcelain fused to base metal	470.00
2752	Porcelain fused to noble metal	*470.00
2790	Full cast, high noble metal	*420.00
2791	Full cast, base metal	420.00
2792	Full cast, noble metal	*420.00

Other restorative services

2915	Recement cast or prefabricated post and core	30.00
2920	Recement crown	44.00
2930	Prefabricated stainless steel crown - primary tooth	135.00
2931	Prefabricated stainless steel crown - permanent tooth	145.00
2932	Prefabricated resin crown	160.00
2933	Prefabricated stainless steel crown with resin window	160.00
2934	Prefabricated coated stainless steel crown - primary tooth	156.00
2940	Sedative filling	60.00
2950	Core buildup, including any pins	110.00
2951	Pin retention - per tooth, in addition to restoration	30.00
2952	Cast post and core, in addition to crown	180.00
2954	Post and core, in addition to crown	78.00

Endodontics

3110	Pulp cap - direct, excluding final restoration	40.00
3120	Pulp cap - indirect, excluding final restoration	40.00
3220	Therapeutic pulpotomy, excluding final restoration	135.00
3221	Pulpal debridement - primary or permanent teeth	140.00
3230	Pulpal therapy - anterior, primary tooth	210.00
3240	Pulpal therapy - posterior, primary tooth	225.00

Root canal therapy

3310	Anterior, excluding final restoration	450.00
3320	Bicuspid, excluding final restoration	525.00
3330	Molar, excluding final restoration	645.00
3346	Retreatment of root canal therapy - anterior	520.00
3347	Retreatment of root canal therapy - posterior	575.00
3348	Retreatment of root canal therapy - molar	700.00
3351	Apexification/recalcification - initial visit	230.00
3352	Apexification/recalcification - interim visit	155.00
3353	Apexification/recalcification - final visit	260.00
3410	Apicoectomy - anterior	420.00
3421	Apicoectomy - bicuspid (first root)	495.00
3425	Apicoectomy - molar (first root)	550.00
3426	Apicoectomy - each additional root	310.00
3430	Retrograde filling - per root	220.00
3450	Root amputation - root	330.00
3920	Hemisection - including any root removal	330.00
3950	Canal preparation and fitting of pre-formed dowel or post	175.00

Periodontics

4210	Gingivectomy/gingivoplasty - four or more contiguous teeth, or bounded teeth spaces, per quadrant	280.00
4211	Gingivectomy/gingivoplasty - one to three contiguous teeth, or bounded teeth spaces, per quadrant	100.00
4240	Gingival flap procedure, with root planing - four or more contiguous teeth, or bounded teeth spaces, per quadrant	350.00
4241	Gingival flap procedure, with root planing - one to three contiguous teeth, or bounded teeth spaces, per quadrant	180.00
4245	Apically positioned flap	400.00
4249	Clinical crown lengthening - hard tissue	320.00
4260	Osseous surgery - four or more contiguous teeth, or bounded teeth spaces, per quadrant	500.00
4261	Osseous surgery - one to three contiguous teeth, or bounded teeth spaces, per quadrant	350.00
4274	Wedge procedure	350.00
4320	Provisional splinting - intracoronal	240.00
4321	Provisional splinting - extracoronal	240.00
4341	Scaling and root planing - four or more contiguous teeth, or bounded teeth spaces, per quadrant	110.00
4355	Full mouth debridement to enable evaluation and diagnosis	100.00
4381	Crevicular tissue treatment - per tooth	50.00
4910	Periodontal maintenance	80.00

Oral surgery

7111	Extraction - coronal remnants, deciduous tooth	65.00
7140	Extraction - erupted tooth or exposed root	70.00
7210	Surgical removal of erupted tooth	150.00
7220	Removal of impacted tooth - soft tissue	150.00
7230	Removal of impacted tooth - partially bony	215.00
7240	Removal of impacted tooth - completely bony	265.00
7250	Surgical removal of residual tooth roots	222.00
7270	Tooth reimplantation and/or stabilization	300.00
7280	Surgical access of an impacted or unerupted tooth	265.00
7281	Surgical exposure of an impacted or unerupted tooth	265.00
7310	Alveoloplasty with extractions, per quadrant	210.00
7311	Alveoloplasty with extractions - one to three teeth, or teeth spaces, per quadrant	140.00
7320	Alveoloplasty not with extractions, per quadrant	240.00
7321	Alveoloplasty not with extractions, one to three teeth, or teeth spaces - per quadrant	140.00
7471	Removal of lateral exostosis	300.00
7510	Incision and drainage of abscess	100.00
7511	Incision and drainage of abscess - complicated	150.00
7960	Frenulectomy	200.00

Other services

9310	Second opinion consultation	None
9630	Other medicaments, intra-sulcular irrigation	25.00
9951	Occlusal adjustment - limited	80.00

Dental exclusions

The following services are not covered by your dental plan

A. Services that are not consistent with professionally recognized standards of practice.

B. Services related to implants or attachments to implants.

C. Cosmetic services, for appearance only, unless specifically listed.

D. 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.

E. Treatment for malignancies, neoplasms (tumors) and cysts as well as hereditary, congenital and/or developmental malformations.

F. Dispensing of drugs not normally supplied in a dental office.

G. Hospitalization charges, dental procedures or services rendered while patient is hospitalized.

H. 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.

I. 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.

J. General anesthesia, including intravenous and inhalation sedation.

K. Dental procedures that cannot be performed in the dental office due to the general health and/or physical limitations of the member.

L. Expenses incurred for dental procedures initiated prior to member's eligibility with Dental Health Services, or after termination of eligibility.

M. Services that are reimbursed by a third party (such as the medical portion of an insurance/health plan or any other third party indemnification).

N. Extractions of non-pathologic, asymptomatic teeth, including extractions and/or surgical procedures for orthodontic reasons.

O. Setting of a fracture or dislocation, surgical procedures related to cleft palate, micrognathia or macrognathia, and surgical grafting procedures.

P. Coordination of benefits with another prepaid managed care dental plan.

Q. Orthodontic treatment of a case in progress and/or retreatment of orthodontic cases.

R. Cephalometric x-rays, tracings, photographs and orthodontic study models.

S. Replacement of lost or broken orthodontic appliances.

T. Changes in orthodontic treatment necessitated by an accident of any kind.

U. Malocclusions so severe or mutilated which are not amenable to ideal orthodontic therapy.

V. Services not specifically covered on the Schedule of Covered Services and Copayments.

Dental limitations

Restrictions on benefits are applied to the following services

A. 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 all contracted specialty care, excluding orthodontics, is $1,000 per member, per contract year.

Orthodontic exclusions

The following services are not covered by your dental plan

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.

G. Orthodontic treatment of a case in progress and/or retreatment of orthodontic cases

H. Cephalometric x-rays, tracings, photographs and orthodontic study models.

I. Replacement of lost or broken orthodontic appliances

J. Changes in treatment necessitated by an accident of any kind.

K. Services which are compensable under worker's compensation or employer liability laws.

L. Malocclusions so severe or mutilated they are not amenable to ideal orthodontic therapy.

Orthodontic limitations

The following are subject to additional charges

A. 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 enrollee 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 coverage, they are no longer eligible for the enrollee 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: None.

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. There is a $1,000 maximum benefit per member, per contract year, excluding orthodontics. See *Services when performed by a Dental Health Services specialist*.

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.