



Code	Description	Pediatric (18 and younger)	Adult (19 and older)	
			General Dentist	Specialist

Plan Information

Failed (no show)/ missed appointments are charged to patient according to office policy.

	Annual Maximum		None	1000
D9543	Office Visit	5	5	0
	Deductible			
	Out of Pocket Maximum - Family	700	N/A	N/A
	Out of Pocket Maximum - Individual	350	N/A	N/A

Services must be performed by a Dental Health Services participating dentist. Specialty services must be pre-authorized and adult patients are subject to copayments listed in specialist column and a \$1000 calendar year maximum. (You are responsible for your copayments based on your specific schedule of covered benefits. Once the services have reached the \$1000 maximum paid by plan, your copayments no longer apply and you are responsible for the cost of treatment at usual and customary fees for the services for the balance of the calendar year). NC indicates the procedure is not covered. For pediatric enrollees (18 years of age and under), all Essential Health Benefits have a "*" and apply to the member out-of-pocket maximum. All other services listed remain covered but do not apply to the member out-of-pocket maximum.

Diagnostic

Full mouth x-rays and/ or a panoramic x-ray are benefits once every 36 months if needed. Exams and bitewing films and up to six periapicals are a benefit once every six months

D0120	periodic oral evaluation - established patient	0	*	0	35
D0140	limited oral evaluation - problem focused	0	*	0	40
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0	*	0	NC
D0150	comprehensive oral evaluation - new or established patient	0	*	0	75
D0160	detailed and extensive oral evaluation - problem focused, by report	40	*	40	35
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	0	*	0	35
D0171	re-evaluation - post-operative office visit	0		0	60
D0180	comprehensive periodontal evaluation - new or established patient	10	*	10	75
D0191	assessment of a patient	10	*	10	40
D0210	intraoral - complete series of radiographic images	0	*	0	40
D0220	intraoral - periapical first radiographic image	0	*	0	15
D0230	intraoral - periapical each additional radiographic image	0	*	0	8
D0240	intraoral - occlusal radiographic image	0	*	0	15
D0250	extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	0	*	0	10
D0251	extra-oral posterior dental radiographic image	0	*	0	30
D0270	bitewing - single radiographic image	0	*	0	10
D0272	bitewings - two radiographic images	0	*	0	15
D0273	bitewings - three radiographic images	0	*	0	15
D0274	bitewings - four radiographic images	0	*	0	30
D0277	vertical bitewings - 7 to 8 radiographic images	0	*	0	30
D0321	other temporomandibular joint radiographic images, by report	100	*	NC	NC
D0322	tomographic survey	350	*	NC	NC
D0330	panoramic radiographic image	18	*	18	50
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	25		25	75
D0350	2D oral/ facial photographic image obtained intra-orally or extra-orally	0		0	40
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	10		10	25
D0415	collection of microorganisms for culture and sensitivity	35	*	35	60
D0425	caries susceptibility tests	10		10	15

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D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	15	15	30
D0460	pulp vitality tests	5	5	20
D0470	diagnostic casts	35	35	35
D0601	caries risk assessment and documentation, with a finding of low risk	5	15	NC
D0602	caries risk assessment and documentation, with a finding of moderate risk	5	15	NC
D0603	caries risk assessment and documentation, with a finding of high risk	5	15	NC

Preventive

D1110	prophylaxis - adult (limited to 1 every 6 months)	5		5	110
D1120	prophylaxis - child (limited to 1 every 6 months)	5	*	5	45
D11AX	prophylaxis - adult (additional beyond 1 in 6 months)	80		80	110
D11CX	prophylaxis - child (additional beyond 1 in 6 months)	80		80	110
D1206	topical application of fluoride varnish	0	*	10	20
D1208	topical application of fluoride – excluding varnish	5	*	8	24
D1310	nutritional counseling for control of dental disease	0		0	NC
D1320	tobacco counseling for the control and prevention of oral disease	0	*	0	NC
D1330	oral hygiene instructions	0		0	NC
D1351	sealant - per tooth	2	*	5	35
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth	50		50	50
D1353	sealant repair – per tooth	2		5	40
D1354	interim caries arresting medicament application- per tooth	20	*	50	50

Space maintainers

D1510	space maintainer - fixed, unilateral – per quadrant	125	*	125	200
D1516	space maintainer - fixed - bilateral, maxillary	150	*	150	150
D1517	space maintainer - fixed - bilateral, mandibular	150	*	150	150
D1520	space maintainer - removable, unilateral - per quadrant	150	*	150	150
D1526	space maintainer - removable - bilateral, maxillary	250	*	250	250
D1527	space maintainer - removable - bilateral, mandibular	250	*	250	250
D1551	re-cement or re-bond bilateral space maintainer - maxillary	15	*	15	50
D1552	re-cement or re-bond bilateral space maintainer - mandibular	15	*	15	50
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	12	*	12	40
D1556	removal of fixed unilateral space maintainer - per quadrant	12	*	12	40
D1557	removal of fixed bilateral space maintainer - maxillary (procedure performed by dentist or practice that did not originally place the appliance)	15	*	15	60
D1558	removal of fixed bilateral space maintainer - mandibular (procedure performed by dentist or practice that did not originally place the appliance)	15	*	15	60

Amalgam restorations - primary or permanent

Restorations include adhesives, bonding agents, liners, bases and/or polishing. Replacement of amalgam fillings within two years of placement is not a covered benefit.

D2140	amalgam - one surface, primary or permanent	25	*	25	100
D2150	amalgam - two surfaces, primary or permanent	35	*	35	115
D2160	amalgam - three surfaces, primary or permanent	40	*	40	125
D2161	amalgam - four or more surfaces, primary or permanent	50	*	50	140

Resin-based composite restorations

Restorations include adhesives, bonding agents, liners, bases and/or polishing. Replacement of Composite fillings within two years of placement is not a covered benefit.

D2330	resin-based composite - one surface, anterior	35	*	35	NC
D2331	resin-based composite - two surfaces, anterior	45	*	45	NC

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D2332	resin-based composite - three surfaces, anterior	55	*	55	NC
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	70	*	70	NC
D2390	resin-based composite crown, anterior	90	*	90	NC
D2391	resin-based composite - one surface, posterior	60	*	60	NC
D2392	resin-based composite - two surfaces, posterior	75	*	75	NC
D2393	resin-based composite - three surfaces, posterior	90	*	90	NC
D2394	resin-based composite - four or more surfaces, posterior	105	*	105	NC

Crowns - single restoration only

Plan Benefit includes all lab charges.

An additional \$25 can be charged with billing code (D27SP) for specialized porcelain such as Captek, Lava, Cercon, etc. See additional Exclusions and Limitations.

D2510	inlay - metallic - one surface	325		575	NC
D2520	inlay - metallic - two surfaces	560		610	NC
D2530	inlay - metallic - three or more surfaces	590		590	NC
D2542	onlay - metallic - two surfaces	560		610	NC
D2543	onlay - metallic - three surfaces	560		610	NC
D2544	onlay - metallic - four or more surfaces	560		610	NC
D2610	inlay - porcelain/ceramic - one surface	550		550	NC
D2620	inlay - porcelain/ceramic - two surfaces	585		585	NC
D2630	inlay - porcelain/ceramic - three or more surfaces	615		615	NC
D2642	onlay - porcelain/ceramic - two surfaces	585		585	NC
D2643	onlay - porcelain/ceramic - three surfaces	615		615	NC
D2644	onlay - porcelain/ceramic - four or more surfaces	615		615	NC
D2650	inlay - resin-based composite - one surface	550		550	NC
D2651	inlay - resin-based composite - two surfaces	585		585	NC
D2652	inlay - resin-based composite - three or more surfaces	615		615	NC
D2662	onlay - resin-based composite - two surfaces	585		585	NC
D2663	onlay - resin-based composite - three surfaces	615		615	NC
D2664	onlay - resin-based composite - four or more surfaces	615		615	NC
D2710	crown - resin-based composite (indirect)	240	*	240	NC
D2712	crown - ¾ resin-based composite (indirect)	240	*	240	NC
D2720	crown - resin with high noble metal	625		675	NC
D2721	crown - resin with predominantly base metal	475		525	NC
D2722	crown - resin with noble metal	600		650	NC
D2740	crown - porcelain/ceramic	580		625	NC
D2750	crown - porcelain fused to high noble metal	625		675	NC
D2751	crown - porcelain fused to predominantly base metal	350	*	525	NC
D2752	crown - porcelain fused to noble metal	350	*	650	NC
D2753	crown - porcelain fused to titanium and titanium alloys	625		670	NC
D2781	crown - 3/4 cast predominantly base metal	475		525	NC
D2782	crown - 3/4 cast noble metal	600		650	NC
D2783	crown - 3/4 porcelain/ceramic	625		675	NC
D2790	crown - full cast high noble metal	625		675	NC
D2791	crown - full cast predominantly base metal	475		525	NC
D2792	crown - full cast noble metal	600		650	NC
D2794	crown - titanium and titanium alloys	625		675	NC
D2799	provisional crown— further treatment or completion of diagnosis necessary prior to final impression	200		200	NC
D27SP	specialized porcelain-all porcelain crown	25		25	NC

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Other restorative services

Re-cementation of a crown, inlay, or onlay within six months of initial placement is considered inclusive of the crown, when performed by the original treating Contract Dentist/Dental Office. See additional Exclusions and Limitations.

D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	25	*	25	NC
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	25	*	25	NC
D2920	re-cement or re-bond crown	25	*	25	NC
D2921	reattachment of tooth fragment, incisal edge or cusp	95	*	95	NC
D2929	prefabricated porcelain/ceramic crown – primary tooth	165		165	NC
D2930	prefabricated stainless steel crown - primary tooth	100	*	100	NC
D2931	prefabricated stainless steel crown - permanent tooth	125	*	125	NC
D2932	prefabricated resin crown	125	*	125	NC
D2933	prefabricated stainless steel crown with resin window	150	*	150	NC
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	150		150	NC
D2940	protective restoration	35	*	35	NC
D2941	interim therapeutic restoration – primary dentition	5	*	5	NC
D2949	restorative foundation for an indirect restoration	30		30	NC
D2950	core buildup, including any pins when required	95	*	95	NC
D2951	pin retention - per tooth, in addition to restoration	25	*	25	NC
D2952	post and core in addition to crown, indirectly fabricated	135		135	NC
D2953	each additional indirectly fabricated post - same tooth	90		90	NC
D2954	prefabricated post and core in addition to crown	120	*	120	NC
D2955	post removal	140		140	NC
D2957	each additional prefabricated post - same tooth	80	*	80	NC
D2960	labial veneer (resin laminate) - chairside	350		350	NC
D2961	labial veneer (resin laminate) - laboratory	500		600	NC
D2962	labial veneer (porcelain laminate) - laboratory	650		675	NC
D2971	additional procedures to construct new crown under existing partial denture framework	50		50	NC
D2975	coping	200		200	NC
D2980	crown repair necessitated by restorative material failure	125	*	125	NC
D2990	resin infiltration of incipient smooth surface lesions	25		25	NC

Endodontics (root canal therapy)

Providers may not charge for the materials used in the procedure to irrigate (wash, disinfect) the canal. The compensation for the root canal treatment includes all materials (regardless of type or brand) and instrumentation involved. Retreatment of a root Canal Therapy during the 12 months following initial treatment is included at no charge to the Member or Plan.

See additional Exclusions and Limitations.

D3110	pulp cap - direct (excluding final restoration)	35		35	35
D3120	pulp cap - indirect (excluding final restoration)	35		35	35
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	55	*	55	65
D3221	pulpal debridement, primary and permanent teeth	55	*	55	80
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	55	*	55	50
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	80	*	80	80
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	80	*	80	95
D3310	endodontic therapy, anterior tooth (excluding final restoration)	325	*	325	400
D3320	endodontic therapy, premolar tooth (excluding final restoration)	350	*	400	500
D3330	endodontic therapy, molar tooth (excluding final restoration)	350	*	575	750
D3331	treatment of root canal obstruction; non-surgical access	175	*	175	190
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	200	*	200	210
D3333	internal root repair of perforation defects	150	*	150	160
D3346	retreatment of previous root canal therapy - anterior	350	*	600	500

Code	Description	Pediatric (18 and younger)		Adult (19 and older)	
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D3347	retreatment of previous root canal therapy - premolar	700		700	600
D3348	retreatment of previous root canal therapy - molar	850		850	850
D3351	apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	250	*	250	250
D3352	apexification/recalcification – interim medication replacement	120	*	120	150
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	300	*	300	325
D3355	pulpal regeneration - initial visit	30		30	95
D3356	pulpal regeneration - interim medication replacement	30		30	80
D3357	pulpal regeneration - completion of treatment	550		550	550
D3410	apicoectomy - anterior	330	*	330	350
D3421	apicoectomy - premolar (first root)	375		375	400
D3425	apicoectomy - molar (first root)	425		425	450
D3426	apicoectomy (each additional root)	140		140	150
D3427	periradicular surgery without apicoectomy	330		330	330
D3430	retrograde filling - per root	120	*	120	140
D3450	root amputation - per root	200		200	225
D3920	hemisection (including any root removal), not including root canal therapy	300		300	350
D3950	canal preparation and fitting of preformed dowel or post	75		75	80

Periodontics

D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	225	*	225	300
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	80	*	80	150
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	80		80	85
D4230	anatomical crown exposure - four or more contiguous teeth or tooth bounded spaces per quadrant	450		450	450
D4231	anatomical crown exposure - one to three teeth or contiguous teeth or tooth bounded spaces per quadrant	350		350	350
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	325		325	350
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	200		200	225
D4245	apically positioned flap	350		350	375
D4249	clinical crown lengthening – hard tissue	375		375	400
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	325		500	650
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	325		360	400
D4263	bone replacement graft – retained natural tooth – first site in quadrant	300		300	325
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant	350		350	370
D4266	guided tissue regeneration - resorbable barrier, per site	300		300	350
D4267	guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	300		300	350
D4268	surgical revision procedure, per tooth	350		400	425
D4270	pedicle soft tissue graft procedure	450		450	450
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	250		250	250
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	445		445	450
D4278	free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	175		175	200
D4341	periodontal scaling and root planing - four or more teeth per quadrant	65	*	65	110

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D4342	periodontal scaling and root planing - one to three teeth per quadrant	40	*	40	75
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	45	*	45	100
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	45	*	45	100
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	35		35	40
D4910	periodontal maintenance (1st and 2nd in year)	40	*	70	100
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	80	*	80	100
D4921	gingival irrigation – per quadrant	25		25	25

Dentures

D5110	complete denture - maxillary	325	*	825	NC
D5120	complete denture - mandibular	325	*	825	NC
D5130	immediate denture - maxillary	325	*	900	NC
D5140	immediate denture - mandibular	325	*	900	NC
D5211	maxillary partial denture - resin base (including any retentive/clasping materials, rests, and teeth)	325	*	675	NC
D5212	mandibular partial denture- resin base (including retentive/clasping materials, rests, and teeth)	325	*	675	NC
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	875		875	NC
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	875		875	NC
D5221	immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	350	*	950	NC
D5222	immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	350	*	950	NC
D5223	immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	950		950	NC
D5224	immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	950		950	NC
D5225	maxillary partial denture - flexible base (including any clasps, rests and teeth)	825		825	NC
D5226	mandibular partial denture - flexible base (including any clasps, rests and teeth)	825		825	NC
D5284	removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	725		725	NC
D5286	removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	725		725	NC

Denture adjustments & repairs

See Exclusions and Limitations.

D5410	adjust complete denture - maxillary	30	*	30	NC
D5411	adjust complete denture - mandibular	30	*	30	NC
D5421	adjust partial denture - maxillary	30	*	30	NC
D5422	adjust partial denture - mandibular	30	*	30	NC
D5511	repair broken complete denture base, mandibular	85	*	130	NC
D5512	repair broken complete denture base, maxillary	85	*	130	NC
D5520	replace missing or broken teeth - complete denture (each tooth)	75	*	125	NC
D5611	repair resin partial denture base, mandibular	135	*	135	NC
D5612	repair resin partial denture base, maxillary	135	*	135	NC
D5621	repair cast partial framework, mandibular	115	*	135	NC
D5622	repair cast partial framework, maxillary	115	*	135	NC
D5630	repair or replace broken retentive/clasping materials per tooth	130	*	130	NC

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D5640	replace broken teeth - per tooth	130	*	130	NC
D5650	add tooth to existing partial denture	100	*	130	NC
D5660	add clasp to existing partial denture - per tooth	110	*	135	NC
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	300	*	500	NC
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	325	*	500	NC
D5710	rebase complete maxillary denture	225	*	225	NC
D5711	rebase complete mandibular denture	225	*	225	NC
D5720	rebase maxillary partial denture	225	*	225	NC
D5721	rebase mandibular partial denture	225	*	225	NC
D5730	reline complete maxillary denture (chairside)	125	*	125	NC
D5731	reline complete mandibular denture (chairside)	125	*	125	NC
D5740	reline maxillary partial denture (chairside)	125	*	125	NC
D5741	reline mandibular partial denture (chairside)	125	*	125	NC
D5750	reline complete maxillary denture (laboratory)	200	*	200	NC
D5751	reline complete mandibular denture (laboratory)	200	*	200	NC
D5760	reline maxillary partial denture (laboratory)	200	*	200	NC
D5761	reline mandibular partial denture (laboratory)	200	*	200	NC
D5810	interim complete denture (maxillary)	325		325	NC
D5811	interim complete denture (mandibular)	325		325	NC
D5820	interim partial denture (maxillary)	325	*	325	NC
D5821	interim partial denture (mandibular)	325	*	325	NC
D5850	tissue conditioning, maxillary	30	*	30	NC
D5851	tissue conditioning, mandibular	30	*	30	NC
D5863	overdenture – complete maxillary	900		900	NC
D5864	overdenture – partial maxillary	900		900	NC
D5865	overdenture – complete mandibular	900		900	NC
D5866	overdenture – partial mandibular	900		900	NC
D5875	modification of removable prosthesis following implant surgery	475		475	NC
D5876	add metal substructure to acrylic full denture (per arch)	130	*	130	NC
D5986	fluoride gel carrier	30		30	NC

Implants

Implants are only available for the adult plans at many participating dental offices and are covered only when performed by the Primary Care Dentists. Check www.dentalhealthservices.com to locate participating dentist offices that offer implant services. Plan includes all lab charges. An additional \$25 can be charged with billing code (D60SP) for specialized porcelain such as Captek, Lava, Ceron, etc.

D6010	surgical placement of implant body: endosteal implant	1500		1500	NC
D6056	prefabricated abutment – includes modification and placement	450		450	NC
D6057	custom fabricated abutment – includes placement	450		450	NC
D6058	abutment supported porcelain/ceramic crown	1150		1150	NC
D6059	abutment supported porcelain fused to metal crown (high noble metal)	1150		1150	NC
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	1000		1000	NC
D6061	abutment supported porcelain fused to metal crown (noble metal)	1125		1125	NC
D6062	abutment supported cast metal crown (high noble metal)	1150		1150	NC
D6063	abutment supported cast metal crown (predominantly base metal)	1000		1000	NC
D6064	abutment supported cast metal crown (noble metal)	1125		1125	NC
D6065	implant supported porcelain/ceramic crown	1150		1150	NC
D6066	implant supported crown - porcelain fused to high noble alloys	1150		1150	NC
D6067	implant supported crown - high noble alloys	1150		1150	NC
D6068	abutment supported retainer for porcelain/ceramic FPD	1150		1150	NC
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	1150		1150	NC
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	1000		1000	NC

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D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	1125	1125	NC
D6072	abutment supported retainer for cast metal FPD (high noble metal)	1150	1150	NC
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	1000	1000	NC
D6074	abutment supported retainer for cast metal FPD (noble metal)	1125	1125	NC
D6075	implant supported retainer for ceramic FPD	1150	1150	NC
D6076	implant supported retainer for FPD - porcelain fused to high noble alloys	1150	1150	NC
D6077	implant supported retainer for metal FPD - high noble alloys	1150	1150	NC
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	40	55	75
D6082	implant supported crown - porcelain fused to predominantly base alloys	1000	1000	NC
D6083	implant supported crown - porcelain fused to noble alloys	1125	1125	NC
D6084	implant supported crown - porcelain fused to titanium and titanium alloys	1150	1150	NC
D6085	provisional implant crown	55	200	NC
D6086	implant supported crown - predominantly base alloys	1000	1000	NC
D6087	implant supported crown - noble alloys	1125	1125	NC
D6088	implant supported crown - titanium and titanium alloys	1150	1150	NC
D6092	re-cement or re-bond implant/abutment supported crown	40	40	NC
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	55	55	NC
D6094	abutment supported crown - titanium and titanium alloys	1150	1150	NC
D6096	remove broken implant retaining screw	50	*	50
D6097	abutment supported crown - porcelain fused to titanium and titanium alloys	1150	1150	NC
D6098	implant supported retainer - porcelain fused to predominantly base alloys	1000	1000	NC
D6099	implant supported retainer for FPD - porcelain fused to noble alloys	1125	1125	NC
D60SP	specialized porcelain- all porcelain abutment retainer	25	25	NC
D6110	implant /abutment supported removable denture for edentulous arch – maxillary	2200	2200	NC
D6111	implant /abutment supported removable denture for edentulous arch – mandibular	2200	2200	NC
D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary	2200	2200	NC
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular	2200	2200	NC
D6120	implant supported retainer – porcelain fused to titanium and titanium alloys	1150	1150	NC
D6121	implant supported retainer for metal FPD – predominantly base alloys	1000	1000	NC
D6122	implant supported retainer for metal FPD – noble alloys	1125	1125	NC
D6123	implant supported retainer for metal FPD – titanium and titanium alloys	1150	1150	NC
D6194	abutment supported retainer crown for FPD – titanium and titanium alloys	1150	1150	NC
D6195	abutment supported retainer - porcelain fused to titanium and titanium alloys	1150	1150	NC

Bridges

Plan includes all lab charges. An additional \$25 can be charged with billing codes (D62SP and D67SP) for specialized porcelain such as Captek, Lava, Cercon, etc.

D6205	pontic - indirect resin based composite	240	240	NC
D6210	pontic - cast high noble metal	625	675	NC
D6211	pontic - cast predominantly base metal	475	525	NC
D6212	pontic - cast noble metal	600	650	NC
D6214	pontic - titanium and titanium alloys	625	675	NC
D6240	pontic - porcelain fused to high noble metal	625	675	NC
D6241	pontic - porcelain fused to predominantly base metal	475	525	NC
D6242	pontic - porcelain fused to noble metal	600	650	NC
D6243	pontic - porcelain fused to titanium and titanium alloys	625	675	NC
D6245	pontic - porcelain/ceramic	625	675	NC
D6250	pontic - resin with high noble metal	625	675	NC
D6251	pontic - resin with predominantly base metal	475	525	NC
D6252	pontic - resin with noble metal	625	675	NC

Code	Description	Pediatric (18 and younger)	Adult (19 and older)		
			General Dentist	Specialist	
D6253	provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	200	200	NC	
D62SP	specialized porcelain- all porcelain pontic	25	25	NC	
D6545	retainer - cast metal for resin bonded fixed prosthesis	310	310	NC	
D6548	retainer - porcelain/ceramic for resin bonded fixed prosthesis	400	400	NC	
D6549	resin retainer – for resin bonded fixed prosthesis	400	400	NC	
D6600	inlay - porcelain/ceramic, two surfaces	585	635	NC	
D6601	retainer inlay - porcelain/ceramic, three or more surfaces	625	675	NC	
D6602	retainer inlay - cast high noble metal, two surfaces	585	635	NC	
D6603	retainer inlay - cast high noble metal, three or more surfaces	625	675	NC	
D6604	retainer inlay - cast predominantly base metal, two surfaces	435	485	NC	
D6605	retainer inlay - cast predominantly base metal, three or more surfaces	475	525	NC	
D6606	retainer inlay - cast noble metal, two surfaces	560	610	NC	
D6607	retainer inlay - cast noble metal, three or more surfaces	600	650	NC	
D6608	retainer onlay - porcelain/ceramic, two surfaces	585	635	NC	
D6609	retainer onlay - porcelain/ceramic, three or more surfaces	625	675	NC	
D6610	retainer onlay - cast high noble metal, two surfaces	585	635	NC	
D6611	retainer onlay - cast high noble metal, three or more surfaces	625	675	NC	
D6612	retainer onlay - cast predominantly base metal, two surfaces	435	485	NC	
D6613	retainer onlay - cast predominantly base metal, three or more surfaces	475	525	NC	
D6614	retainer onlay - cast noble metal, two surfaces	560	610	NC	
D6615	retainer onlay - cast noble metal, three or more surfaces	600	650	NC	
D6624	retainer inlay - titanium	525	575	NC	
D6634	retainer onlay - titanium	625	675	NC	
D6710	retainer crown - indirect resin based composite	475	525	NC	
D6720	retainer crown - resin with high noble metal	625	575	NC	
D6721	retainer crown - resin with predominantly base metal	475	525	NC	
D6722	retainer crown - resin with noble metal	600	650	NC	
D6740	retainer crown - porcelain/ceramic	625	675	NC	
D6750	retainer crown - porcelain fused to high noble metal	625	675	NC	
D6751	retainer crown - porcelain fused to predominantly base metal	475	525	NC	
D6752	retainer crown - porcelain fused to noble metal	600	650	NC	
D6753	retainer crown - porcelain fused to titanium and titanium alloys	625	675	NC	
D6780	retainer crown - 3/4 cast high noble metal	625	675	NC	
D6781	retainer crown - 3/4 cast predominantly base metal	475	525	NC	
D6782	retainer crown - 3/4 cast noble metal	600	650	NC	
D6783	retainer crown - 3/4 porcelain/ceramic	625	675	NC	
D6784	retainer crown ¾ - titanium and titanium alloys	625	675	NC	
D6790	retainer crown - full cast high noble metal	625	675	NC	
D6791	retainer crown - full cast predominantly base metal	475	525	NC	
D6792	retainer crown - full cast noble metal	600	650	NC	
D6793	provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	200	200	NC	
D6794	retainer crown - titanium and titanium alloys	625	625	NC	
D67SP	specialized porcelain- all porcelain abutment	25	25	NC	
D6930	re-cement or re-bond fixed partial denture	40	*	40	NC
D6980	fixed partial denture repair necessitated by restorative material failure	100	*	100	NC

Oral Surgery

See Exclusions and Limitations

D7111	extraction, coronal remnants - primary tooth	40	*	50	80
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Code	Description	Pediatric (18 and younger)		Adult (19 and older)	
				General Dentist	Specialist
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	60	*	60	75
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	135	*	135	135
D7220	removal of impacted tooth - soft tissue	150	*	150	155
D7230	removal of impacted tooth - partially bony	180	*	180	195
D7240	removal of impacted tooth - completely bony	215	*	215	235
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	265	*	265	275
D7250	removal of residual tooth roots (cutting procedure)	150	*	150	175
D7251	coronectomy – intentional partial tooth removal	210	*	210	220
D7260	oroantral fistula closure	325	*	NC	NC
D7261	primary closure of a sinus perforation	300	*	NC	NC
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	270	*	270	270
D7280	exposure of an unerupted tooth	125		125	180
D7282	mobilization of erupted or malpositioned tooth to aid eruption	275		275	275
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	250	*	250	250
D7286	incisional biopsy of oral tissue-soft	100	*	100	135
D7287	exfoliative cytological sample collection	100	*	NC	NC
D7288	brush biopsy - transepithelial sample collection	50	*	50	55
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	110		110	175
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	150		150	100
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	140	*	140	165
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	80	*	80	11
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	325	*	NC	NC
D7350	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	325	*	NC	NC
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	300	*	NC	NC
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	325	*	NC	NC
D7465	destruction of lesion(s) by physical or chemical method, by report	250	*	NC	NC
D7471	removal of lateral exostosis (maxilla or mandible)	350	*	NC	NC
D7472	removal of torus palatinus	350	*	NC	NC
D7473	removal of torus mandibularis	350	*	NC	NC
D7510	incision and drainage of abscess - intraoral soft tissue	100	*	100	105
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	125		125	130
D7520	incision and drainage of abscess - extraoral soft tissue	200	*	NC	NC
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	145	*	NC	NC
D7540	removal of reaction producing foreign bodies, musculoskeletal system	325	*	NC	NC
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	300	*	NC	NC
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	325	*	NC	NC
D7670	alveolus - closed reduction, may include stabilization of teeth	325	*	NC	NC
D7770	alveolus - open reduction stabilization of teeth	325	*	NC	NC
D7910	suture of recent small wounds up to 5 cm	150	*	NC	NC
D7911	complicated suture - up to 5 cm	250	*	NC	NC
D7912	complicated suture - greater than 5 cm	325	*	NC	NC
D7922	placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	10		10	15
D7960	frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	150	*	150	190
D7963	frenuloplasty	225	*	225	250
D7970	excision of hyperplastic tissue - per arch	150	*	150	190

Code	Description	Pediatric (18 and younger)		Adult (19 and older)	
				General Dentist	Specialist
D7971	excision of pericoronal gingiva	60	*	60	70
D7981	excision of salivary gland, by report	325	*	NC	NC
D7982	sialodochoplasty	60	*	60	150
D7983	closure of salivary fistula	325	*	NC	NC
D7990	emergency tracheotomy	325	*	NC	NC
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	150	*	NC	NC

Other Services

See Exclusions and Limitations

D9110	palliative (emergency) treatment of dental pain - minor procedure	30	*	30	60
D9120	fixed partial denture sectioning	35	*	35	125
D9210	local anesthesia not in conjunction with operative or surgical procedures	10		10	30
D9211	regional block anesthesia	15	*	15	50
D9212	trigeminal division block anesthesia	75	*	75	80
D9215	local anesthesia in conjunction with operative or surgical procedures	0		0	35
D9219	evaluation for moderate sedation, deep sedation or general anesthesia	40		40	65
D9222	deep sedation/general anesthesia – first 15 minutes	200	*	300	300
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment	200	*	300	300
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	40	*	40	40
D9239	intravenous moderate (conscious) sedation/analgesia – first 15 minutes	170	*	300	300
D9243	intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	170	*	300	300
D9248	non-intravenous conscious sedation	135	*	225	225
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	20	*	20	50
D9410	house/extended care facility call	55	*	NC	NC
D9420	hospital or ambulatory surgical center call	250	*	NC	NC
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	25		25	45
D9440	office visit - after regularly scheduled hours	40	*	40	45
D9450	case presentation, detailed and extensive treatment planning	0		0	35
D9610	therapeutic parenteral drug, single administration	20	*	20	20
D9612	therapeutic parenteral drugs, two or more administrations, different medications	30	*	30	50
D9630	drugs or medicaments dispensed in the office for home use	15	*	15	20
D9910	application of desensitizing medicament	15		15	40
D9911	application of desensitizing resin for cervical and/or root surface, per tooth	15		15	40
D9920	behavior management, by report	75	*	NC	NC
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	70	*	70	70
D9932	cleaning and inspection of removable complete denture, maxillary	15		15	NC
D9933	cleaning and inspection of removable complete denture, mandibular	15		15	NC
D9934	cleaning and inspection of removable partial denture, maxillary	15		15	NC
D9935	cleaning and inspection of removable partial denture, mandibular	15		15	NC
D9941	fabrication of athletic mouthguard	125		125	NC
D9942	repair and/or reline of occlusal guard	75		75	115
D9951	occlusal adjustment - limited	35		35	100
D9952	occlusal adjustment - complete	150		150	500
D9970	enamel microabrasion	75		75	75
D9971	odontoplasty 1 - 2 teeth; includes removal of enamel projections	100		100	100
D9972	external bleaching - per arch - performed in office	150		150	NC
D9973	external bleaching - per tooth	40		40	NC
D9974	internal bleaching - per tooth	75		75	NC
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays	200		200	200

Code	Description	Pediatric (18 and younger)	Adult (19 and older)	
			General Dentist	Specialist
D9991	dental case management – addressing appointment compliance barriers	0	0	25
D9992	dental case management – care coordination	0	0	25
D9993	dental case management – motivational interviewing	0	0	25
D9994	dental case management – patient education to improve oral health literacy	0	0	25
D9995	teledentistry- synchronous; real-time encounter	15	*	NC
D9996	teledentistry- asynchronous; information stored and forwarded to dentist for subsequent review	10	*	NC

Orthodontics

Orthodontia Benefits for members under 19 must be preauthorized and will be covered according to the EHB requirements when medically necessary. Medically Necessary Orthodontia is considered: A. Cleft palate; or B. Cleft palate with cleft lip; and C. Whose orthodontia treatment began prior to 21 years of age; or whose surgical corrections of cleft palate or cleft lip were not completed prior to age 21; D. PA is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate/ cleft lip must be included in the client's record and a copy sent with the PA request; E. Documentation in the client's record must include diagnosis, length and type of treatment; F. Payment for appliance therapy includes the appliance and all follow-up visits; G. Orthodontists evaluate orthodontia treatment for cleft palate/ cleft lip as two phases. Stage one is generally the use of an activator (palatal expander) and stage two is generally the placement of fixed appliances (banding). Medically Necessary Orthodontia copayment is paid over 2 years – First half due in year 1 and second half is due in year 2. The child copayment only applies to medically necessary orthodontia. Non-medically necessary orthodontia (D8070-D8693) is available for members. Limited orthodontic treatments (D8010-D8040) and interceptive treatment of primary dentition (D8050) and interceptive treatment of transitional dentition (D8060) will be prorated based on the estimated treatment time in comparison to the listed copayments for comprehensive (24-month) treatment of transitional, adolescent, and adult dentition.

D8070	Comprehensive orthodontic treatment of the transitional dentition	3395		3395
D8080	Comprehensive orthodontic treatment of the adolescent dentition	3395		3395
D8090	Comprehensive orthodontic treatment of the adult dentition	3495		3495
D8210	Removable appliance therapy	550		550
D8220	Fixed appliance therapy	550		550
D8660	Pre-orthodontic treatment examination to monitor growth and development	40		40
D8670	Periodic orthodontic treatment visit	5		5
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	315		315
D8681	Removable orthodontic retainer adjustment	30		30
D8690	Orthodontic treatment (alternative billing to a contract fee)	0		0
D8698	re-cement or re-bond fixed retainer – maxillary	45		45
D8699	re-cement or re-bond fixed retainer – mandibular	45		45
	Medically Necessary Orthodontia is for Cleft palate; Cleft palate with cleft lip and the following anomalies: Hemifacial microsomia; Craniosynostosis syndromes; Cleidocranial dental dysplasia; Arthrogryposis; Marfan syndrome. Must be preauthorized.	700	*	NC

Orthodontic treatment services using Invisalign are coded with the same CDT codes—appropriate to scope of treatment—for pre-authorizations and claims. There is an additional fee allowance of \$1200 for treatment rendered with Invisalign in addition to the prorated fees for limited and fees for comprehensive orthodontic treatment. Dental Health Services uses the modifier “IN” (example: D8080-IN) for reporting of Invisalign treatment.

Denturists

Covered Denturist Services and Copayments when services are received from a licensed Dental Health Services' Denturist. Only Plastic Teeth will be covered by Dental Health Services. Upgrades on dentures will be the member's responsibility (at a 20% discount). Denturist benefit subject to existence and availability of a licensed denturist within a 30-mile radius of a Member. Members may elect to travel to the nearest participating denturist for services.

D0140	limited oral evaluation - problem focused	40	*	40	40
D5110	Complete denture - maxillary	325	*	700	NC
D5120	Complete denture - mandibular	325	*	700	NC
D5130	Immediate denture - maxillary	325	*	725	NC
D5140	Immediate denture - mandibular	325	*	725	NC
D5211	maxillary partial denture - resin base (including any retentive/clasping materials, rests, and teeth)	325	*	675	NC
D5212	mandibular partial denture- resin base (including retentive/clasping materials, rests, and teeth)	325	*	675	NC
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	875		750	NC

Code	Description	Pediatric (18 and younger)		Adult (19 and older)	
				General Dentist	Specialist
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	875		750	NC
D5221	immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	350	*	775	NC
D5222	immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	350	*	775	NC
D5223	immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	950		775	NC
D5224	immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	950		775	NC
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	825		750	NC
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	825		750	NC
D5410	Adjust complete denture - maxillary	30	*	20	NC
D5411	Adjust complete denture - mandibular	30	*	20	NC
D5421	Adjust partial denture - maxillary	30	*	20	NC
D5422	Adjust partial denture - mandibular	30	*	20	NC
D5511	Repair broken complete denture base, mandibular	85	*	100	NC
D5512	Repair broken complete denture base, maxillary	85	*	100	NC
D5520	Replace missing or broken teeth - complete denture (each tooth)	75	*	100	NC
D5611	repair resin partial denture base, mandibular	135	*	110	NC
D5612	repair resin partial denture base, maxillary	135	*	110	NC
D5621	repair cast partial framework, mandibular	115	*	110	NC
D5622	repair cast partial framework, maxillary	115	*	110	NC
D5630	repair or replace broken retentive/clasping materials per tooth	130	*	100	NC
D5640	Replace broken teeth - per tooth	130	*	100	NC
D5650	Add tooth to existing partial denture	100	*	100	NC
D5660	add clasp to existing partial denture - per tooth	110	*	105	NC
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	300	*	375	NC
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	325	*	375	NC
D5710	Rebase complete maxillary denture	225	*	195	NC
D5711	Rebase complete mandibular denture	225	*	195	NC
D5720	Rebase maxillary partial denture	225	*	195	NC
D5721	Rebase mandibular partial denture	225	*	195	NC
D5730	Reline complete maxillary denture (chairside)	125	*	110	NC
D5731	Reline complete mandibular denture (chairside)	125	*	110	NC
D5740	Reline maxillary partial denture (chairside)	125	*	110	NC
D5741	Reline mandibular partial denture (chairside)	125	*	110	NC
D5750	Reline complete maxillary denture (laboratory)	200	*	170	NC
D5751	Reline complete mandibular denture (laboratory)	200	*	170	NC
D5760	Reline maxillary partial denture (laboratory)	200	*	170	NC
D5761	Reline mandibular partial denture (laboratory)	200	*	170	NC
D5810	Interim complete denture (maxillary)	325		300	NC
D5811	Interim complete denture (mandibular)	325		300	NC
D5820	Interim partial denture (maxillary)	325	*	300	NC
D5821	Interim partial denture (mandibular)	325	*	300	NC
D5850	Tissue conditioning, maxillary	30	*	25	NC
D5851	Tissue conditioning, mandibular	30	*	25	NC
D5863	Overdenture – complete maxillary	900		725	NC
D5864	Overdenture – partial maxillary	900		725	NC
D5865	Overdenture – complete mandibular	900		725	NC
D5866	Overdenture – partial mandibular	900		725	NC



SmartSmile Plus-ECsm Plan

Exclusions and Limitations of Benefits

Adult Limitations and Exclusions (19 years old and older)

Limitations:

The following are limitations on covered benefits.

- A. Authorized treatment is rendered only by your selected participating primary dentist. Services provided by a dentist other than the member's designated participating primary dentist, except for emergency dental conditions are not covered. (See item C. below). Specialty coverage must be preauthorized and referred by their participating primary dentist when treated at a specialist.
- B. Limitation on the frequency and appropriateness of services:
 - 1. D0120 Periodic oral evaluations are limited to one per six months.
 - 2. D0210 and D0330 Intraoral complete series films and panoramic films limited to once every three years.
 - 3. D1110 - Prophylaxis (removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition) limited to 1 per 6 months.
 - 4. D1206 and D1208 Fluoride is limited to one per six months.
 - 5. D4341 or D4342 - Periodontal scaling and root planing - limited to four quadrants per six months; and 2 quadrants per visit is recommended.
 - 6. D4910 - Periodontal Maintenance - Limited to one per three month period.
 - 7. Crowns, bridges, pontics and denture codes D5110 thru D5281 - Full/partial dentures (upper and / or lower) - limited to one per five year period. New dentures are covered only if the existing denture cannot be made satisfactory by either a relin or repair. Lost or stolen appliances are the responsibility of the patient.
 - 8. Fixed bridges are optional and not covered for patients under the age of 16.
- C. Emergency Dental Condition – A dental condition that manifests itself by acute symptoms of sufficient severity requiring immediate treatment. This includes, acute infection, acute abscesses, severe tooth pain, unusual swelling of the face or gums, or a tooth that has been avulsed (knocked out).
- D. Optional services (all cases in which the member selects a plan of treatment that is considered unnecessary by the dentist). The member is

responsible for fee-for-service rates. This does not apply to standard covered restorative procedures which offer a choice of material.

- E. Crowns and Bridges – crowns and bridges are limited to 10 in a 12 month period. Additional crowns and bridges are subject to a \$200 copayment increase per procedure.
- F. Unsatisfactory patient-doctor relationship: Dental Health Services' participating dentists reserve the right to limit or deny services to a member who fails to follow the prescribed course of treatment, repeatedly fails to keep appointments, fails to pay applicable copayments, fails to maintain a satisfactory doctor/patient relationship, or obtains services by fraud or deception.
- G. Submit claims within 180 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 dentist unless the member submits the claim to Dental Health Services within 180 days after treatment.
- H. Denturist benefit subject to existence and availability of a licensed denturist within a 30 mile radius of a Member. Members may elect to travel to the nearest participating denturist for services.
- I. Benefits are only available if work is completed in member's participating dentist's office.
- J. Not all participating dentists can perform all dental procedures. Please verify what services your selected dentist can perform for you. Some complicated extractions, periodontal treatment, osseous surgery and root canal treatment may be referred to a specialist at the discretion of the general dentist.
- K. Coverage for services are only available during period of enrollment.
- L. Implants are only available for the adult plans at specific participating dental offices. Check www.dentalhealthservices.com to locate participating dentist offices which offer implant services.
- M. Orthodontic extractions are covered if medically necessary for Orthodontic treatment.
- N. Services performed by a Specialist for adults 19 and older are subject to the specialist copayment amount. Dental Health Services pays up to \$1000 in specialty claims per calendar year per adult enrollee.

Exclusions:

The following are not covered by your dental plan.

- A. Services not specifically listed or listed as NC (not 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. 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.
- D. Any dental procedure that cannot be performed in the

dental office due to the general health and/or physical limitations of the member, unless specifically covered on the pediatric EHB plan for children under 19.

- E. Services that are reimbursed by a third party such as the medical portion of a health insurance plan or any other third party indemnification. (The member may be responsible for the payment of usual and customary charges to his/her Dentist for services that are reimbursed by a third party.)
- F. Cosmetic services for appearance only are not covered.
- G. Extractions for asymptomatic teeth are not covered.
- H. Full mouth rehabilitation or reconstruction is not a covered benefit. Fixed restorative procedures requiring extensive restorative treatment and/or increase or decrease of the arch horizontal or vertical dimension are considered full mouth rehabilitation
- I. Correction of malocclusion, gnathological recordings, full mouth equilibration, periodontal splinting, temporary processed functional crowns/appliances and realignment of teeth are not covered.

Adult orthodontia and non-medically necessary children's orthodontia is offered at a discounted fee. Comprehensive orthodontic treatment copayment amounts are based on a typical 24-month case. If case extends beyond 24 months, the cost of treatment in progress will be pro-rated and converted to the Orthodontist's actual fee-for-service amount.

Orthodontic Limitations:

The following are limitations on covered benefits.

- A. Changes in treatment necessitated by accident of any kind.
- B. Services which are compensable under Worker's Compensation or employer liability laws.
- C. Lingual brackets for cosmetic reasons can be charged to the member above the basic Orthodontia benefit.
- D. Malocclusions too severe or mutilated which are not amenable to ideal orthodontic therapy.

Orthodontic Exclusions:

The following are not covered by your dental plan.

- A. Cephalometric x-rays, dental x-rays for orthodontic purposes.
- B. Tracings and photographs.
- C. Study Models.
- D. Replacement of lost or broken appliances.
- E. Retreatment of orthodontic cases.
- F. Treatment of a case in progress at inception of eligibility.
- G. Treatment and/or surgical procedures related to cleft palate, micrognathia or microdontia.
- H. Treatment related to Temporomandibular joint disturbances and/or hormonal imbalances.
- I. Any dental procedures considered to be within the field of general dentistry, including but not limited to:
 - 1. Myofunctional therapy.
 - 2. General anesthetics including intravenous and inhalation sedation.

- 3. Dental services of any nature performed in a hospital. Services which are compensable under Worker's Compensation or employer liability laws.
- J. Payment by Dental Health Services or any special discounted orthodontic copayment for treatment rendered or required after member is no longer eligible for coverage (i.e. current premium unpaid). The cost of treatment in progress will be prorated and converted to the Orthodontist's actual fee-for-service amount.

Pediatric Limitations and Exclusions (18 years old and under)

The following are limitations on covered benefits:

Authorized treatment is rendered only by your designated participating primary dentist. Services provided by a dentist other than the member's designated participating primary dentist, except for emergency dental conditions, are not covered. (See item C. below). Specialty coverage must be preauthorized and referred by their participating primary dentist when treated by a specialist.

Diagnostic services are covered with the following limitations and exclusions:

- A. Exams (billed as D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations: D0150: once every 12 months when performed by the same practitioner; D0150: twice every 12 months only when performed by different practitioners; D0180: once every 12 months; D0160 only once every 12 months when performed by the same practitioner; for each emergency dental condition episode, use D0140 for the initial exam. Use D0170 for related dental follow-up exams; Covers oral exams by medical practitioners when the medical practitioner is an oral surgeon.
- B. Radiographs: Routine radiographs once every 12 months; Bitewing radiographs for routine screening once every 12 months; A maximum of 6 radiographs for any one emergency; For members under age 6, radiographs may be billed separately every 12 months as follows: D0220 -once; D0230 -a maximum of 5 times; D0270-a maximum of 2, or D0272 once; for panoramic (D0330) or intra-oral complete series (D0210) once every 5 years, but both cannot be done within the 5 year period; Members must be a minimum of 6 years old for billing intra-oral complete series (D0210).

The minimum standards for reimbursement of intra-oral complete series are: For insureds ages 6 through 11- a minimum of 10 periapicals and 2 bitewings for a total of 12 films; For members ages 12 and older- a minimum of 10 periapicals and 4 bitewings for a total of 14 films; If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), reimburse for the complete series; Additional films may be covered if dentally or medically appropriate, e.g., fractures (Refer to OAR 410-123-1060 and 410-120-0000);

If it is determined the number of radiographs submitted to be excessive, payment for some or all radiographs of the same tooth or area may be denied. The exception to these limitations is if the member is new to the office or clinic and the office or clinic was unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records must be included in the insured's records. Digital radiographs, if printed, should be on photo paper to assure sufficient quality of images.

Preventive Services are covered with following limitations and exclusions:

- A. Prophylaxis: For children (18 and under)- Limited to twice per 12 months. Additional prophylaxis benefit provisions may be available for members with high risk oral conditions due to disease process, pregnancy, medications or other medical treatments or conditions. Severe periodontal disease, rampant caries and/or for persons with disabilities who cannot perform adequate daily oral health care;
- B. Appropriate Current Dental Terminology (CDT) coding: D1110 (Prophylaxis- Adult)- for members 14 years of age and older; and D1120 (Prophylaxis- Child)- for members under 14 years of age.
- C. Topical fluoride treatment: For children (under age 19)- Limited to 2 every 12 months; For children under 7 years of age who have limited access to a dental practitioner, topical fluoride varnish may be applied by a medical practitioner during a medical visit: Bill using a professional claim format with the appropriate CDT code (D1206- topical fluoride varnish or D1208 fluoride excluding varnish); An oral screening by a

medical practitioner is not a separate billable service and is included in the office visit.

Additional topical fluoride treatments may be available, up to a total of 4 conditions apply: high-risk conditions are documented through billing D0603 and oral health factors are clearly documented in chart notes for the following insureds who: have high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries, are pregnant; have physical disabilities and cannot perform adequate, daily oral health care; have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily oral health care; or are under 7 years old with high-risk oral health factors, such as poor oral hygiene, deep pits and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.

- D. Sealants (D1351): covered only for children under 16 years of age; limits coverage to: Permanent molars; and only one sealant on a permanent more in 5 years, except for visible evidence of clinical failure. Use D1353 as repair is needed.
- E. Space management: covers fixed and removable space maintainers (D1510, D1515, D1520, and D1525) only for insured 18 and under; No reimbursement for replacement of lost or damaged removable space maintainers.

Restorative Services are covered with the following limitations and exclusions:

- A. Amalgam and composite: covers resin-based composite restorations only for anterior teeth; Resin-based composite crowns on anterior teeth (D2390) are only covered for insureds under 19; No reimbursement of resin-based composite restorations for posterior teeth (D2391-D2394); Limits payment of covered restorations to the maximum restoration fee of four surfaces per tooth. Refer to the American Dental Association (ADA) CDT codebook for definitions of restorative procedures. Providers must combine and bill multiple surface restorations as one line per tooth using the appropriate code. Providers may not bill multiple surface restorations performed on a single tooth on the same day on separate lines. For example, if tooth #30 has a buccal amalgam

and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four or more surfaces); No reimbursement for an amalgam or composite restoration and a crown on the same tooth surface once in each treatment episode regardless of the number or combination of restorations. The restoration fee includes payment for occlusal adjustment and polishing of the restoration.

Crowns and related services are covered with the following limitations and exclusions:

- A. Covers crowns only when: There is significant loss of clinical crown and no other restoration will restore function and the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures.
- B. Covers core buildup (D2950) only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture and only when done in conjunction with a crown. Less than 50% of the tooth structure must be remaining for coverage of the core buildup. No coverage of core buildup if the crown is not covered under the insured's benefit package
- C. Retention pins (D2951) is per tooth, not per pin;
- D. No coverage of the following services: Endodontic therapy alone (with or without a post); Aesthetics (cosmetics);
- E. Covers the following only: Provisional crowns (D2799) - allowed as an interim restoration of at least six months during restorative treatment to allow adequate healing or completion of other procedures. This is not to be used as a temporary crown for a routine prosthetic restoration; Prefabricated plastic crowns (D2932) allowed only for anterior teeth, permanent or primary; Stainless steel crowns (D2930/D2931) allowed only for anterior primary teeth and posterior permanent or primary teeth; Prefabricated stainless steel crowns with resin window (D2933) allowed only for anterior teeth, permanent or primary; Prefabricated post and core in addition to crowns (D2954/D2957). Permanent crowns (resin-based composite D2710 and D2712, and porcelain fused to metal (PFM) D2751 and D2752) as follows: Limited to teeth numbers 6-11, 22 and 27 only, if dentally appropriate; Limited to four (4) in a seven-year period. This limitation includes any replacement crowns allowed according to (E)(i) of this rule; Only for members at least 16 years of age; and rampant caries are arrested and the members demonstrate a period of good oral hygiene before prosthetics are proposed.
- F. Crown replacement: Permanent crown replacement limited to once every 7 years; all other crown replacement limited to once every 5 years; and possible exceptions to crown replacement limitations due to acute trauma, based on the

following factors: extent of crown damage; extent of damage to other teeth or crowns; tooth is restorable without other surgical procedures; and if loss of tooth would result in coverage of removable prosthetic.

- G. Crown repair, by report (D2980) is limited to only anterior teeth.

Endodontics are covered with the following limitations and exclusions:

- A. Pulp capping: Includes direct and indirect pulp caps in the restoration fee; no additional payment shall be made for members.
- B. Endodontic therapy: Pulpal therapy on primary teeth (D3230 and D3240) is covered only for children 18 and under; For permanent teeth: anterior and bicuspid endodontic therapy (D3310 and D3320) is covered for all members. Molar endodontic therapy (D3330) is covered only for first and second molars; and covers endodontics only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures.
- C. Endodontic retreatment and apicoectomy/periradicular surgery: Does not cover retreatment of a previous root canal or apicoectomy/periradicular surgery for bicuspid or molars; Limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when: Crown-to-root ratio is 50:50 or better; The tooth is restorable without other surgical procedures; or if the loss of tooth would result in the need for removable prosthodontics.
- D. Retrograde filling (D3430) is covered only when done in conjunction with a covered apicoectomy of an anterior tooth. It does not allow separate reimbursement for open-and-drain as a palliative procedure when the root canal is completed on the same date of service.
- E. Covers endodontics if the tooth is restorable within the benefit coverage package.
- F. Apexification/ recalcification and pulpal regeneration procedures:
- G. Limits payment for apexification to a maximum of 5 treatments on permanent teeth only; Apexification/ recalcification and pulpal regeneration procedures are covered.

Periodontal Services are covered with the following limitations and exclusions:

- A. Surgical periodontal services: Gingivectomy/ Gingivoplasty (D4210 and D4211) is limited to coverage

for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Orlant hyperplasia; includes six months routine postoperative care.

- B. Non-surgical periodontal services: periodontal scaling and root planing (D4341 and D4342) is limited to once every 2 years with a maximum of two quadrants on one date of service, except in extraordinary circumstances. Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 5 mm or greater: D4341 is allowed for quadrants with at least 4 or more teeth with pockets 5 mm or greater; D4342 is allowed for quadrants with at least 2 teeth with pocket depths of 5 mm or greater.
- C. Prior authorization for more frequent scaling and root planing may be requested when medically/dentally necessary due to periodontal disease as defined above and during pregnancy.
- D. Full mouth debridement (D4355) is limited to only once every 2 years.
- E. Periodontal maintenance (D4910) is limited to once every 6 months only when it follows periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years.
- F. D4910 is limited to once every 12 months unless it is medically/dentally necessary such as due to presence of periodontal disease during pregnancy. Member's records must support the need for increased periodontal maintenance (chart notes, pocket depths and radiographs); Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs. D4910 will not be covered if performed on the same date of service as any of the following procedures: D1110 (Prophylaxis-adult); D1120 (Prophylaxis -child); D4210 (Gingivectomy or gingivoplasty- four or more contiguous teeth or bounded teeth spaces per quadrant); D4211 (Gingivectomy or gingivoplasty- one to three contiguous teeth or bounded teeth spaces per quadrant); D4341 (Periodontal scaling and root planning -four or more teeth per quadrant); D4342 (Periodontal scaling and root planning -one to three teeth per quadrant); D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis).

Removable Prosthodontic Services are covered with the following limitations and exclusions:

- A. Only members 16 years and older are eligible for removable resin base partial dentures (D5211 D5212) and full dentures (complete or immediate, D5110-D5140). The copayment for the partial and full dentures includes payment for

adjustments during the 6 month period following delivery. Members must have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth.

- B. Replacement of removable partial or full dentures when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following once in 10 years for members at least 16 years old and only if dentally appropriate. This does not imply that replacement of dentures or partials must be done once every 10 years but only when dentally appropriate. The 10 year limitations apply to the member regardless of the member's enrollment status at the time of last denture or partial was received. Replacement of partial dentures with full dentures is payable ten years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant replacement.
- C. Replacement of all teeth and acrylic on cast metal framework (D5670-D5671) is limited to members age 16 and older a maximum of once every 10 years, per arch. Ten years or more must have passed since the original partial denture was delivered to be considered as a replacement partial. So a new partial denture is not reimbursable for another 10 years since it was originally delivered
- D. Denture rebase procedures covers rebases only if a reline may not adequately solve the problem; limits payment for rebase to once every 3 years. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing.
- E. Denture reline procedures limits payment for reline of complete or partial dentures to once every 3 years. May make exceptions to this limitation under the same conditions warranting replacement.

- F. Laboratory relines are not payable prior to 6 months after placement of an immediate denture; and are limited to once every 3 years.
- G. Interim partial dentures (D5820-D5821), also referred to as “flippers”, are allowed if the member has one or more anterior teeth missing. Replacement of interim partial dentures is limited to once every 5 years, but only when dentally appropriate.
- H. Tissue conditioning is limited to once per denture unit in conjunction with immediate dentures; and is allowed once prior to new prosthetic placement.

Maxillofacial Prosthetic Services are covered with the following limitations and exclusions:

- A. Fluoride gel carrier (D5986) is limited to those patients whose severity of oral disease causes the cleaning and fluoride treatments allowed to be insufficient. The dental practitioner must document failure of those options prior to use of the fluoride gel carrier.
- B. All other maxillofacial prosthetics (D5900-D5999) are medical services and not covered under dental. Refer to the “Covered and Non-Covered Dental Services” document and OAR 410-123-1220.
- C. Covers core buildup for retainer (D6793) only when necessary to retain a cast restoration due to extensive loss of tooth structure and only when done in conjunction with a crown. Less than 50% of the tooth structure must be remaining for coverage of the core buildup. Shall not cover core buildup if the crown is not covered under the member’s benefits.

Oral Surgery procedures are covered with the following limitations and exclusions:

- A. Services must be performed in a dental office setting (including an oral surgeon’s office).
- B. Such services include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs and follow-up visits.
- C. Refer to OAR 410-123-1160 for any prior authorization requirements for specific procedures. Bill the following procedures using the professional claim format and the appropriate American Medical Association (AMA) CPT procedure and ICD-9 diagnosis codes: Procedures that are a result of a medical condition (i.e., fractures, cancer). Services requiring hospital dentistry that are the result of a medical condition/diagnosis (i.e., fracture, cancer). Refer to the “Covered and Non-Covered Dental Services” document to see a list of CDT procedure codes on the

HSC Prioritized List that may also have CPT medical codes. See OAR 410-123-1220. The procedures listed as “medical” on the table may be covered as medical procedures, and the table may not be all-inclusive of every dental code that has a corresponding medical code. Oral surgical services performed in an ASC or an inpatient or outpatient hospital setting require prior authorization.

- D. All codes listed as “by report” require an operative report.
- E. Covers payment for tooth re-implantation only in cases of traumatic avulsion where there are good indications of success.
- F. Biopsies collected are reimbursed as a dental service. Laboratory services of biopsies are not reimbursed as a dental procedure but may be reimbursed as a medical service.
- G. Does not cover surgical excisions of soft tissue lesions (D7410- D7415).
- H. Extractions- Includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction. Dry socket is not considered a separate service.
- I. Surgical extractions: Include local anesthesia and routine post-operative care.
- J. Surgical removal of impacted teeth or removal of residual tooth roots is limited to treatment for teeth that have acute infection or abscess, severe tooth pain, and/or unusual swelling of the face or gums. It does not cover alveoloplasty in conjunction with extractions (D7310 and D7311) separately from the extraction.
- K. Frenulectomy/Frenulotomy (D7960) and frenuloplasty (D7963) is limited to once per lifetime per arch.
- L. Maxillary labial frenulectomy is limited to members age 12 and older
- M. Frenulectomy/frenuloplasty is limited to the following situations: when the insured has ankyloglossia; when the condition is deemed to cause gingival recession; or when the condition is deemed to cause movement of the gingival margin when the frenum is placed under tension;

Medically Necessary Orthodontia

Limits orthodontia services and extractions to eligible members with Cleft palate; or Cleft palate with cleft lip; and whose orthodontia treatment began while 18 and under; or whose surgical corrections of cleft palate or cleft lip were not completed prior to age 19. Pre-authorization is required for orthodontia

exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate/cleft lip must be included in the member's record and a copy sent with the prior authorization request. Documentation must include diagnosis, length and type of treatment.

When qualified for Medically Necessary Orthodontia payment for appliance therapy includes the appliance and all follow-up visits. Orthodontists evaluate orthodontia treatment for cleft palate/cleft lip as two phases. Stage one is generally the use of an activator (palatal expander) and stage two is generally the placement of fixed appliances (banding). Reimburse each phase individually (separately). Member shall pay for orthodontia in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the insured transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist must refund any unused amount of payment, after applying the following formula: Total payment minus \$300.00 (for banding) multiplied by the percentage of treatment remaining. Use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining.

1. D8660 Pre-authorization required (reimbursement for required orthodontia records is included);
2. D8010-D8690 Pre-authorization required.

Adjunctive General and Other Services are covered with the following limitations and exclusions:

- A. Fixed partial denture sectioning (D9120) is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment.
- B. General anesthesia or IV sedation is for members with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure (D9222, D9223, D9239 and D9243); D9222 or D9239 should be billed for the first 15 minutes and; D9223 or D9243 for each additional 15-minute period, up to three hours on the same day of service. Each 15-minute period represents a quantity of one.
- C. Nitrous Oxide (D9230) is covered per date of service, not by time.
- D. Oral pre-medication anesthesia for conscious sedation (D9248) is limited to members under 13 years of age and limited to 4 times per year.
- E. Limits reimbursement of house/extended care facility call (D9410) only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience.

Dental Health Services

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