Dental Health Services

Schedule of Covered Services and Copayments

SmartSmile Plus- EC (OR-824i)

Plan Information

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

		Copayment Child 18 and under	Copayment Adult 19+
	Annual Maximum	None	None
D9543	**Office Visit**	**5**	5
	Deductible		0
	Out of Pocket Maximum - Family	700	N/A
	Out of Pocket Maximum - Individual	350	N/A
	Specialty Services Covered	Yes	No

Services must be performed by a Dental Health Services participating dentist. Specialty services must be pre-authorized and are only available for children 18 and under.
NC indicates the procedure is not covered.
For pediatric enrollees (18 years of age and under), all Essential Health Benefits listed in bold 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

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D0120	**periodic oral evaluation - established patient**	**0**	0
D0140	**limited oral evaluation - problem focused**	**0**	0
D0145	**oral evaluation for a patient under three years of age and counseling with primary caregiver**	**0**	0
D0150	**comprehensive oral evaluation - new or established patient**	**0**	0
D0160	detailed and extensive oral evaluation - problem focused, by report	40	40
D0170	**re-evaluation - limited, problem focused (established patient; not post-operative visit)**	**0**	0
D0171	re-evaluation – post-operative office visit	0	0
D0180	**comprehensive periodontal evaluation - new or established patient**	**10**	10
D0191	assessment of a patient	10	10
D0210	**intraoral - complete series of radiographic images**	**0**	0
D0220	**intraoral - periapical first radiographic image**	**0**	0
D0230	**intraoral - periapical each additional radiographic image**	**0**	0
D0240	intraoral - occlusal radiographic image	0	0
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0	0
D0251	extra-oral posterior dental radiographic image	0	0
D0270	**bitewing - single radiographic image**	**0**	0
D0272	**bitewings - two radiographic images**	**0**	0
D0273	bitewings - three radiographic images	0	0
D0274	bitewings - four radiographic images	0	0
D0277	vertical bitewings - 7 to 8 radiographic images	0	0
D0310	sialography	150	NC
D0320	temporomandibular joint arthrogram, including injection	100	NC
D0321	other temporomandibular joint radiographic images, by report	100	NC
D0330	panoramic radiographic image	18	18
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	25	25
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0	0
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	10	10
D0415	collection of microorganisms for culture and sensitivity	35	35
D0425	caries susceptibility tests	10	10
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
D0460	pulp vitality tests	5	5
D0470	diagnostic casts	35	35
D0601	caries risk assessment and documentation, with a finding of low risk	5	15
D0602	caries risk assessment and documentation, with a finding of moderate risk	5	15
D0603	caries risk assessment and documentation, with a finding of high risk	5	15

Preventive

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D1110	**prophylaxis - adult (limited to 1 every 6 months)**	**5**	5

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D1120	**prophylaxis - child (limited to 1 every 6 months)**	**5**	5
D11AX	prophylaxis - adult (additional beyond 1 in 6 months)	80	80
D11CX	prophylaxis - child (additional beyond 1 in 6 months)	80	80
D1206	**topical application of fluoride varnish**	**0**	10
D1208	topical application of fluoride – excluding varnish	5	8
D1310	nutritional counseling for control of dental disease	0	0
D1320	tobacco counseling for the control and prevention of oral disease	0	0
D1330	oral hygiene instructions	0	0
D1351	**sealant - per tooth**	**2**	5
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth	50	50
D1353	sealant repair – per tooth	2	5
D1354	interim caries arresting medicament application- per tooth	20	50

Space maintainers

D1510	**space maintainer - fixed - unilateral**	**125**	125
D1515	**space maintainer - fixed - bilateral**	**150**	150
D1520	**space maintainer - removable - unilateral**	**150**	150
D1525	**space maintainer - removable -bilateral**	**250**	250
D1550	re-cement or re-bond space maintainer	15	15
D1555	removal of fixed space maintainer distal	15	15
D1575	shoe space maintainer – fixed – unilateral	125	125

Amalgam restorations - primary or permanent

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

Resin-based composite restorations

D2330	**resin-based composite - one surface, anterior**	**35**	35
D2331	**resin-based composite - two surfaces, anterior**	**45**	45
D2332	**resin-based composite - three surfaces, anterior**	**55**	55
D2335	**resin-based composite - four or more surfaces or involving incisal angle (anterior)**	**70**	70
D2390	**resin-based composite crown, anterior**	**90**	90
D2391	resin-based composite - one surface, posterior	60	60
D2392	resin-based composite - two surfaces, posterior	75	75
D2393	resin-based composite - three surfaces, posterior	90	90
D2394	resin-based composite - four or more surfaces, posterior	105	105

Crowns - single restoration only

Plan copayments includes all lab charges. There are no additional charges for specialized porcelain.

D2510	inlay - metallic - one surface	325	575
D2520	inlay - metallic - two surfaces	560	610
D2530	inlay - metallic - three or more surfaces	590	590
D2542	onlay - metallic - two surfaces	560	610
D2543	onlay - metallic - three surfaces	560	610
D2544	onlay - metallic - four or more surfaces	560	610
D2610	inlay - porcelain/ceramic - one surface	550	550
D2620	inlay - porcelain/ceramic - two surfaces	585	585
D2630	inlay - porcelain/ceramic - three or more surfaces	615	615
D2642	onlay - porcelain/ceramic - two surfaces	585	585
D2643	onlay - porcelain/ceramic - three surfaces	615	615
D2644	onlay - porcelain/ceramic - four or more surfaces	615	615
D2650	inlay - resin-based composite - one surface	550	550
D2651	inlay - resin-based composite - two surfaces	585	585
D2652	inlay - resin-based composite - three or more surfaces	615	615
D2662	onlay - resin-based composite - two surfaces	585	585
D2663	onlay - resin-based composite - three surfaces	615	615
D2664	onlay - resin-based composite - four or more surfaces	615	615
D2710	**crown - resin-based composite (indirect)**	**240**	240
D2712	**crown - ¾ resin-based composite (indirect)**	**240**	240
D2720	crown - resin with high noble metal	625	675
D2721	crown - resin with predominantly base metal	475	525
D2722	crown - resin with noble metal	600	650
D2740	crown - porcelain/ceramic	625	675

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D2750	crown - porcelain fused to high noble metal	625	675
D2751	**crown - porcelain fused to predominantly base metal**	**350**	525
D2752	**crown - porcelain fused to noble metal**	**350**	650
D2780	crown - 3/4 cast high noble metal	625	675
D2781	crown - 3/4 cast predominantly base metal	475	525
D2782	crown - 3/4 cast noble metal	600	650
D2783	crown - 3/4 porcelain/ceramic	625	675
D2790	crown - full cast high noble metal	625	675
D2791	crown - full cast predominantly base metal	475	525
D2792	crown - full cast noble metal	600	650
D2794	crown - titanium	625	675
D2799	**provisional crown– further treatment or completion of diagnosis necessary prior to final impression**	**200**	200

Other restorative services

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

Endodontics

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

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D3346	**retreatment of previous root canal therapy - anterior**	**600**	600
D3347	retreatment of previous root canal therapy - premolar	700	700
D3348	retreatment of previous root canal therapy - molar	850	850
D3351	**apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)**	**250**	250
D3352	**apexification/recalcification – interim medication replacement**	**120**	120
D3353	**apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)**	**300**	300
D3355	pulpal regeneration - initial visit	30	30
D3356	pulpal regeneration - interim medication replacement	30	30
D3357	pulpal regeneration - completion of treatment	550	550
D3410	**apicoectomy - anterior**	**330**	330
D3421	apicoectomy - premolar (first root)	375	375
D3425	apicoectomy - molar (first root)	425	425
D3426	apicoectomy (each additional root)	140	140
D3427	periradicular surgery without apicoectomy	330	330
D3430	**retrograde filling - per root**	**120**	120
D3450	root amputation - per root	200	200
D3920	hemisection (including any root removal), not including root canal therapy	300	300
D3950	canal preparation and fitting of preformed dowel or post	75	75

Periodontics

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D4210	**gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant**	**225**	225
D4211	**gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant**	**80**	80
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	80	80
D4230	anatomical crown exposure - four or more contiguous teeth or tooth bounded spaces per quadrant	450	450
D4231	anatomical crown exposure - one to three teeth or contiguous teeth or tooth bounded spaces per quadrant	350	350
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	325	325
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	200	200
D4245	apically positioned flap	350	350
D4249	clinical crown lengthening – hard tissue	375	375
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
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
D4263	bone replacement graft – retained natural tooth – first site in quadrant	300	300
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant	350	350
D4266	guided tissue regeneration - resorbable barrier, per site	300	300
D4267	guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	300	300
D4268	surgical revision procedure, per tooth	350	400
D4270	pedicle soft tissue graft procedure	450	450
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	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
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
D4341	**periodontal scaling and root planing - four or more teeth per quadrant**	**65**	65
D4342	**periodontal scaling and root planing - one to three teeth per quadrant**	**40**	40
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	45	45
D4355	**full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit**	**45**	45
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	35	35
D4910	**periodontal maintenance (**limited to 1 every 3 months**)**	**40**	70

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	80	80
D4921	gingival irrigation – per quadrant	25	25

Dentures

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D5110	**complete denture - maxillary**	**325**	825
D5120	**complete denture - mandibular**	**325**	825
D5130	**immediate denture - maxillary**	**325**	900
D5140	**immediate denture - mandibular**	**325**	900
D5211	**maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)**	**325**	675
D5212	**mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth**	**325**	675
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	875	875
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	875	875
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	950	950
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	950	950
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	950	950
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	950	950
D5225	maxillary partial denture - flexible base (including any clasps, rests and teeth)	825	825
D5226	mandibular partial denture - flexible base (including any clasps, rests and teeth)	825	825
D5282	removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	500	500
D5283	removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	500	500

Denture adjustments & repairs

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D5410	adjust complete denture - maxillary	30	30
D5411	adjust complete denture - mandibular	30	30
D5421	adjust partial denture - maxillary	30	30
D5422	adjust partial denture - mandibular	30	30
D5511	repair broken complete denture base, mandibular	85	130
D5512	repair broken complete denture base, maxillary	85	130
D5520	replace missing or broken teeth - complete denture (each tooth)	75	125
D5611	repair resin partial denture base, mandibular	135	135
D5612	repair resin partial denture base, maxillary	135	135
D5621	repair cast partial framework, mandibular	115	135
D5622	repair cast partial framework, maxillary	115	135
D5630	repair or replace broken retentive/ clasping materials -per tooth	130	130
D5640	replace broken teeth - per tooth	130	130
D5650	add tooth to existing partial denture	100	130
D5660	add clasp to existing partial denture - per tooth	110	135
D5670	**replace all teeth and acrylic on cast metal framework (maxillary) replace**	**300**	500
D5671	**all teeth and acrylic on cast metal framework (mandibular) rebase**	**325**	500
D5710	**complete maxillary denture rebase**	**225**	225
D5711	**complete mandibular denture rebase**	**225**	225
D5720	**maxillary partial denture rebase**	**225**	225
D5721	**mandibular partial denture reline**	**225**	225
D5730	**complete maxillary denture (chairside)**	**125**	125
D5731	**reline complete mandibular denture (chairside)**	**125**	125
D5740	**reline maxillary partial denture (chairside)**	**125**	125
D5741	**reline mandibular partial denture (chairside)**	**125**	125
D5750	**reline complete maxillary denture (laboratory)**	**200**	200
D5751	**reline complete mandibular denture (laboratory)**	**200**	200
D5760	**reline maxillary partial denture (laboratory)**	**200**	200
D5761	**reline mandibular partial denture (laboratory)**	200	200
D5810	interim complete denture (maxillary)	325	325
D5811	interim complete denture (mandibular)	325	325
D5820	**interim partial denture (maxillary)**	**325**	325
D5821	**interim partial denture (mandibular)**	**325**	325
D5850	**tissue conditioning, maxillary tissue**	**30**	30
D5851	**conditioning, mandibular**	**30**	30
D5863	overdenture – complete maxillary	900	900
D5864	overdenture – partial maxillary	900	900
D5865	overdenture – complete mandibular	900	900
D5866	overdenture – partial mandibular	900	900
D5875	modification of removable prosthesis following implant surgery	475	475

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D5986	**fluoride gel carrier**	**30**	30

Implants

Plan copayments includes all lab charges. There are no additional charges for specialized porcelain.

D6010	surgical placement of implant body: endosteal implant	1500	1500
D6056	prefabricated abutment – includes modification and placement	450	450
D6057	custom fabricated abutment – includes placement	450	450
D6058	abutment supported porcelain/ceramic crown	1150	1150
D6059	abutment supported porcelain fused to metal crown (high noble metal)	1150	1150
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	1000	1000
D6061	abutment supported porcelain fused to metal crown (noble metal)	1125	1125
D6062	abutment supported cast metal crown (high noble metal)	1150	1150
D6063	abutment supported cast metal crown (predominantly base metal)	1000	1000
D6064	abutment supported cast metal crown (noble metal)	1125	1125
D6065	implant supported porcelain/ceramic crown	1150	1150
D6066	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	1150	1150
D6067	implant supported metal crown (titanium, titanium alloy, high noble metal)	1150	1150
D6068	abutment supported retainer for porcelain/ceramic FPD	1150	1150
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	1150	1150
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	1000	1000
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	1125	1125
D6072	abutment supported retainer for cast metal FPD (high noble metal)	1150	1150
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	1000	1000
D6074	abutment supported retainer for cast metal FPD (noble metal)	1125	1125
D6075	implant supported retainer for ceramic FPD	1150	1150
D6076	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	1150	1150
D6077	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	1150	1150
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
D6085	provisional implant crown	55	200
D6092	re-cement or re-bond implant/abutment supported crown	40	40
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	55	55
D6094	abutment supported crown - (titanium)	500	1150
D6110	implant /abutment supported removable denture for edentulous arch – maxillary	2200	2200
D6111	implant /abutment supported removable denture for edentulous arch – mandibular	2200	2200
D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary	2200	2200
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular	2200	2200
D6194	abutment supported retainer crown for FPD (titanium)	500	1150

Bridges

Plan copayments includes all lab charges. There are no additional charges for specialized porcelain.

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

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D6252	pontic - resin with noble metal	625	675
D6253	provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	200	200
D6545	retainer - cast metal for resin bonded fixed prosthesis	310	310
D6548	retainer - porcelain/ceramic for resin bonded fixed prosthesis	400	400
D6549	resin retainer – for resin bonded fixed prosthesis	400	400
D6600	inlay - porcelain/ceramic, two surfaces	585	635
D6601	retainer inlay - porcelain/ceramic, three or more surfaces	625	675
D6602	retainer inlay - cast high noble metal, two surfaces	585	635
D6603	retainer inlay - cast high noble metal, three or more surfaces	625	675
D6604	retainer inlay - cast predominantly base metal, two surfaces	435	485
D6605	retainer inlay - cast predominantly base metal, three or more surfaces	475	525
D6606	retainer inlay - cast noble metal, two surfaces	560	610
D6607	retainer inlay - cast noble metal, three or more surfaces	600	650
D6608	retainer onlay - porcelain/ceramic, two surfaces	585	635
D6609	retainer onlay - porcelain/ceramic, three or more surfaces	625	675
D6610	retainer onlay - cast high noble metal, two surfaces	585	635
D6611	retainer onlay - cast high noble metal, three or more surfaces	625	675
D6612	retainer onlay - cast predominantly base metal, two surfaces	435	485
D6613	retainer onlay - cast predominantly base metal, three or more surfaces	475	525
D6614	retainer onlay - cast noble metal, two surfaces	560	610
D6615	retainer onlay - cast noble metal, three or more surfaces	600	650
D6624	retainer inlay - titanium	525	575
D6634	retainer onlay - titanium	625	675
D6710	retainer crown - indirect resin based composite	475	525
D6720	retainer crown - resin with high noble metal	625	575
D6721	retainer crown - resin with predominantly base metal	475	525
D6722	retainer crown - resin with noble metal	600	650
D6740	retainer crown - porcelain/ceramic	625	675
D6750	retainer crown - porcelain fused to high noble metal	625	675
D6751	retainer crown - porcelain fused to predominantly base metal	475	525
D6752	retainer crown - porcelain fused to noble metal	600	650
D6780	retainer crown - 3/4 cast high noble metal	625	675
D6781	retainer crown - 3/4 cast predominantly base metal	475	525
D6782	retainer crown - 3/4 cast noble metal	600	650
D6783	retainer crown - 3/4 porcelain/ceramic	625	675
D6790	retainer crown - full cast high noble metal	625	675
D6791	retainer crown - full cast predominantly base metal	475	525
D6792	retainer crown - full cast noble metal	600	650
D6793	provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	200	200
D6794	retainer crown - titanium	625	625
D6930	re-cement or re-bond fixed partial denture	40	40
D6980	fixed partial denture repair necessitated by restorative material failure	100	100

Oral Surgery

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D7111	**extraction, coronal remnants - primary tooth**	**40**	50
D7140	**extraction, erupted tooth or exposed root (elevation and/or forceps removal)**	**60**	60
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	135	135
D7220	**removal of impacted tooth - soft tissue**	**150**	150
D7230	**removal of impacted tooth - partially bony**	**180**	180
D7240	**removal of impacted tooth - completely bony**	**215**	215
D7241	**removal of impacted tooth - completely bony, with unusual surgical complications**	**265**	265
D7250	**removal of residual tooth roots (cutting procedure)**	**150**	150
D7251	coronectomy – intentional partial tooth removal	210	210
D7260	**oroantral fistula closure**	**325**	NC
D7261	primary closure of a sinus perforation	300	NC

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D7270	**tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth**	**270**	270
D7280	exposure of an unerupted tooth	125	125
D7282	mobilization of erupted or malpositioned tooth to aid eruption	275	275
D7285	**incisional biopsy of oral tissue-hard (bone, tooth)**	**250**	250
D7286	**incisional biopsy of oral tissue-soft**	**100**	100
D7287	exfoliative cytological sample collection	100	NC
D7288	**brush biopsy - transepithelial sample collection**	**50**	50
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	110	110
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	150	150
D7320	**alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant**	**140**	140
D7321	**alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant**	**80**	80
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	325	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
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	300	NC
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	325	NC
D7465	destruction of lesion(s) by physical or chemical method, by report	250	NC
D7471	**removal of lateral exostosis (maxilla or mandible)**	**350**	NC
D7510	**incision and drainage of abscess - intraoral soft tissue**	**100**	100
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	125	125
D7520	**incision and drainage of abscess - extraoral soft tissue**	**200**	NC
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	145	NC
D7540	removal of reaction producing foreign bodies, musculoskeletal system	325	NC
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	300	NC
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	325	NC
D7670	alveolus - closed reduction, may include stabilization of teeth	325	NC
D7770	alveolus - open reduction stabilization of teeth	325	NC
D7910	suture of recent small wounds up to 5 cm	150	NC
D7911	complicated suture - up to 5 cm	250	NC
D7912	complicated suture - greater than 5 cm	325	NC
D7960	**frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure**	**150**	150
D7963	**frenuloplasty**	**225**	225
D7970	excision of hyperplastic tissue - per arch	150	150
D7971	**excision of pericoronal gingiva**	**60**	60
D7980	surgical sialolithotomy	325	NC
D7981	excision of salivary gland, by report	325	NC
D7982	sialodochoplasty	60	60
D7983	closure of salivary fistula	325	NC
D7990	emergency tracheotomy	325	NC
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	150	NC

Other Services

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D9110	palliative (emergency) treatment of dental pain - minor procedure	30	30
D9120	**fixed partial denture sectioning**	**35**	35
D9210	local anesthesia not in conjunction with operative or surgical procedures	10	10
D9211	regional block anesthesia	15	15
D9212	trigeminal division block anesthesia	75	75
D9215	**local anesthesia in conjunction with operative or surgical procedures**	**0**	0
D9219	evaluation for moderate sedation, deep sedation or general anesthesia	40	40
D9222	**deep sedation/general anesthesia – first 15 minutes**	**200**	300
D9223	**deep sedation/general anesthesia – each subsequent 15 minute**	**200**	300
D9230	**inhalation of nitrous oxide/ analgesia, anxiolysis**	**40**	40
D9239	**intravenous moderate (conscious) sedation/analgesia – first 15 minutes**	**170**	300
D9243	**intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment**	**170**	300
D9248	**non-intravenous conscious sedation**	**135**	225
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	20	20

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D9410	**house/extended care facility call**	**55**	NC
D9420	hospital or ambulatory surgical center call	250	NC
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	25	25
D9440	office visit - after regularly scheduled hours	40	40
D9450	case presentation, detailed and extensive treatment planning	0	0
D9610	therapeutic parenteral drug, single administration	20	20
D9612	therapeutic parenteral drugs, two or more administrations, different medications	30	30
D9630	**drugs or medicaments dispensed in the office for home use**	**15**	15
D9910	application of desensitizing medicament	15	15
D9911	application of desensitizing resin for cervical and/or root surface, per tooth	15	15
D9920	behavior management, by report	75	NC
D9930	**treatment of complications (post-surgical) - unusual circumstances, by report**	**70**	70
D9932	cleaning and inspection of removable complete denture, maxillary	15	15
D9933	cleaning and inspection of removable complete denture, mandibular	15	15
D9934	cleaning and inspection of removable partial denture, maxillary	15	15
D9935	cleaning and inspection of removable partial denture, mandibular	15	15
D9941	fabrication of athletic mouthguard	125	125
D9942	repair and/or reline of occlusal guard	75	75
D9944	occlusal guard- hard appliance, full arch	350	350
D9945	occlusal guard- soft appliance, full arch	350	350
D9951	occlusal adjustment - limited	35	35
D9952	occlusal adjustment - complete	150	150
D9970	enamel microabrasion	75	75
D9971	odontoplasty 1 - 2 teeth; includes removal of enamel projections	100	100
D9972	external bleaching - per arch - performed in office	150	150
D9973	external bleaching - per tooth	40	40
D9974	internal bleaching - per tooth	75	75
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays	200	200
D9991	dental case management – addressing appointment compliance barriers	0	0
D9992	dental case management – care coordination	0	0
D9993	dental case management – motivational interviewing	0	0
D9994	dental case management – patient education to improve oral health literacy	0	0

Orthodontics

Orthodontia Benefits for children 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 19 years of age; or whose surgical corrections of cleft palate or cleft lip were not completed prior to age 19;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.

Medically Necessary Orthodontia is for Cleft palate; Cleft palate with cleft lip and the following anomalies: Hemifacial microsmia; Craniosynostosis syndromes; Cleidocranial dental dysplasia; Arthrogryposis; Marfan syndrome. Must be preauthorized.	**700**	NC

Non-medically necessary orthodontia (D8070-D8693) is available for members. Limited treatment (D8010-D8060) will be prorated based off of the comprehensive treatment amount listed.

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
D8693	Re-cement or re-bond fixed retainer	45	45

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).

Code	Description	Copayment Child 18 and under	Copayment Adult 19+
D0140	**limited oral evaluation - problem focused**	**40**	40
D5110	**Complete denture - maxillary**	**325**	700
D5120	**Complete denture - mandibular**	**325**	700
D5130	**Immediate denture - maxillary**	**325**	725
D5140	**Immediate denture - mandibular**	**325**	725
D5211	**Maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)**	**325**	675
D5212	**Mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)**	**325**	675
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	875	750
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	875	750
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	950	775
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	950	775
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	950	775
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	950	775
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	825	750
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	825	750
D5282	removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	500	500
D5283	removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	500	500
D5410	Adjust complete denture - maxillary	30	20
D5411	Adjust complete denture - mandibular	30	20
D5421	Adjust partial denture - maxillary	30	20
D5422	Adjust partial denture - mandibular	30	20
D5511	Repair broken complete denture base, mandibular	85	100
D5512	Repair broken complete denture base, maxillary	85	100
D5520	Replace missing or broken teeth - complete denture (each tooth)	75	100
D5611	repair resin partial denture base, mandibular	135	110
D5612	repair resin partial denture base, maxillary	135	110
D5621	repair cast partial framework, mandibular	115	110
D5622	repair cast partial framework, maxillary	115	110
D5630	repair or replace broken retentive/ clasping materials - per tooth	130	100
D5640	Replace broken teeth - per tooth	130	100
D5650	Add tooth to existing partial denture	100	100
D5660	add clasp to existing partial denture - per tooth	110	105
D5670	**Replace all teeth and acrylic on cast metal framework (maxillary)**	**300**	375
D5671	**Replace all teeth and acrylic on cast metal framework (mandibular)**	**325**	375
D5710	**Rebase complete maxillary denture**	**225**	195
D5711	**Rebase complete mandibular denture**	**225**	195
D5720	**Rebase maxillary partial denture**	**225**	195
D5721	**Rebase mandibular partial denture**	**225**	195
D5730	**Reline complete maxillary denture (chairside)**	**125**	110
D5731	**Reline complete mandibular denture (chairside)**	125	110
D5740	**Reline maxillary partial denture (chairside)**	**125**	110
D5741	**Reline mandibular partial denture (chairside)**	**125**	110
D5750	**Reline complete maxillary denture (laboratory)**	**200**	170
D5751	**Reline complete mandibular denture (laboratory)**	**200**	170
D5760	**Reline maxillary partial denture (laboratory)**	**200**	170
D5761	**Reline mandibular partial denture (laboratory)**	**200**	170
D5810	Interim complete denture (maxillary)	325	300
D5811	Interim complete denture (mandibular)	325	300
D5820	**Interim partial denture (maxillary)**	**325**	300
D5821	**Interim partial denture (mandibular)**	**325**	300
D5850	**Tissue conditioning, maxillary**	**30**	25
D5851	**Tissue conditioning, mandibular**	**30**	25
D5863	Overdenture – complete maxillary	900	725
D5864	Overdenture – partial maxillary	900	725
D5865	Overdenture – complete mandibular	900	725
D5866	Overdenture – partial mandibular	900	725

Dental Health Services

Exclusions and Limitations of Benefits

SmartSmile Plus- EC℠ Plan

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). Children under 19, have specialty coverage and 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 reline 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.

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. Treatment by a specialist is not covered for anyone 19 and over. It may be available at a discount, unless specialist coverage is provided through an employer sponsored group plan.

C. 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.

D. 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.

E. 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.

F. 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.)
G. Cosmetic services for appearance only are not covered.
H. Extractions for asymptomatic teeth are not covered.
I. 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
J. 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.
   4. 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). Children under 19 have specialty coverage and 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. Apexificationlrecalcification 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., Oilantin 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 exlcusions:

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 reimburseable 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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