

Code	Service	Copayment
	Office visit charge - per visit	10.00
	Failed/no-show appointment without 24-hour notice	40.00

Services when performed by a Dental Health Services participating dentist

Diagnostic

D0120	Periodic oral evaluation	2.00
D0140	Limited oral evaluation - problem-focused	2.00
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	2.00
D0150	Comprehensive oral evaluation - new or established patient	5.00
D0180	Comprehensive periodontal evaluation - new or established patient	20.00
D0210	Intraoral - complete series of x-rays (including bitewings)	25.00
D0220	Intraoral - periapical first film	7.00
D0230	Intraoral - periapical each additional film	4.00
D0240	Intraoral - occlusal film	9.00
D0250	Extraoral - first film	9.00
D0260	Extraoral - each additional film	6.00
D0270	Bitewing - single film	10.00
D0272	Bitewings - two films	13.00
D0273	Bitewings - three films	15.00
D0274	Bitewings - four films	17.00
D0330	Panoramic film	25.00
D0460	Pulp vitality tests	None
D0470	Diagnostic casts	35.00

Preventive

Prophylaxis (teeth cleaning) - maximum of one per 6 months, two per contract year

D1110	Prophylaxis - adult	20.00
D1120	Prophylaxis - child	15.00
D1203	Topical application of fluoride (without prophylaxis) - child	5.00
D1204	Topical application of fluoride (without prophylaxis) - adult	5.00
D1206	Topical fluoride varnish, therapeutic application for moderate to high caries risk patients	12.00
D1330	Oral hygiene instructions	None
D1351	Sealant - per tooth	10.00
D1510	Space maintainer - fixed - unilateral	125.00
D1515	Space maintainer - fixed - bilateral	150.00
D1520	Space maintainer - removable - unilateral	125.00
D1525	Space maintainer - removable - bilateral	150.00
D1550	Recementation of space maintainer	10.00
D1555	Removal of fixed space maintainer	10.00

Restorative

D2140	Amalgam - one surface, primary or permanent	42.00
D2150	Amalgam - two surfaces, primary or permanent	47.00
D2160	Amalgam - three surfaces, primary or permanent	57.00
D2161	Amalgam - four or more surfaces, primary or permanent	72.00
D2330	Resin-based composite - one surface, anterior	62.00
D2331	Resin-based composite - two surfaces, anterior	72.00
D2332	Resin-based composite - three surfaces, anterior	82.00
D2335	Resin-based composite - four or more surfaces, or involving incisal angle (anterior)	95.00
D2391	Resin-based composite - one surface, posterior	80.00
D2392	Resin-based composite - two surfaces, posterior	95.00
D2393	Resin-based composite - three surfaces, posterior	110.00
D2394	Resin-based composite - four or more surfaces, posterior	125.00

Code	Service	Copayment
D2510	Inlay - metallic - one surface	*320.00
D2520	Inlay - metallic - two surfaces	*360.00
D2530	Inlay - metallic - three or more surfaces	*390.00
D2542	Onlay - metallic - two surfaces	*360.00
D2543	Onlay - metallic - three surfaces	*390.00
D2544	Onlay - metallic - four or more surfaces	*390.00
D2610	Inlay - porcelain/ceramic - one surface	*320.00
D2620	Inlay - porcelain/ceramic - two surfaces	*360.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	*390.00
D2642	Onlay - porcelain/ceramic - two surfaces	*360.00
D2643	Onlay - porcelain/ceramic - three surfaces	*390.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	*390.00
D2650	Inlay - resin-based composite - one surface	*320.00
D2651	Inlay - resin-based composite - two surfaces	*360.00
D2652	Inlay - resin-based composite - three or more surfaces	*390.00
D2662	Onlay - resin-based composite - two surfaces	*360.00
D2663	Onlay - resin-based composite - three surfaces	*390.00
D2664	Onlay - resin-based composite - four or more surfaces	*390.00
D2710	Crown - resin-based composite (indirect)	240.00
D2712	Crown - 3/4 resin based composite (indirect)	240.00
D2740	Crown - porcelain/ceramic substrate	*400.00
D2750	Crown - porcelain fused to high noble metal	*400.00
D2751	Crown - porcelain fused to predominantly base metal	*400.00
D2752	Crown - porcelain fused to noble metal	*400.00
D2780	Crown - 3/4 cast high noble metal	*400.00
D2781	Crown - 3/4 cast predominantly base metal	*400.00
D2782	Crown - 3/4 cast noble metal	*400.00
D2783	Crown - 3/4 porcelain/ceramic	*400.00
D2790	Crown - full cast high noble metal	*400.00
D2791	Crown - full cast predominantly base metal	*400.00
D2792	Crown - full cast noble metal	*400.00
D2794	Crown - titanium	*400.00
D2910	Recement inlay, onlay, or partial coverage restoration	15.00
D2915	Recement cast or prefabricated post and core	15.00
D2920	Recement crown	15.00
D2930	Prefabricated stainless steel crown - primary tooth	75.00
D2931	Prefabricated stainless steel crown - permanent tooth	125.00
D2932	Prefabricated resin crown	125.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	110.00
D2940	Sedative filling	30.00
D2950	Core buildup, including any pins	95.00
D2951	Pin retention - per tooth, in addition to restoration	35.00
D2952	Post and core in addition to crown, indirectly fabricated	*100.00
D2954	Prefabricated post and core in addition to crown	100.00

** Patient is responsible for the cost of any laboratory charges*

Endodontics

D3110	Pulp cap - direct (excluding final restoration)	35.00
D3120	Pulp cap - indirect (excluding final restoration)	35.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	55.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	80.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	80.00
D3310	Anterior root canal therapy (excluding final restoration)	300.00
D3320	Bicuspid root canal therapy (excluding final restoration)	355.00
D3330	Molar root canal therapy (excluding final restoration)	590.00

Code	Service	Copayment
Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	225.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	80.00
D4249	Clinical crown lengthening - hard tissue	350.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	85.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	45.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	55.00
D4910	Periodontal maintenance	50.00

Removable prosthodontics

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

D5110	Complete denture - maxillary	*425.00
D5120	Complete denture - mandibular	*425.00
D5130	Immediate denture - maxillary	*440.00
D5140	Immediate denture - mandibular	*440.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	*450.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	*450.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	*500.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	*500.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	*500.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	*500.00
D5410	Adjust complete denture - maxillary	30.00
D5411	Adjust complete denture - mandibular	30.00
D5421	Adjust partial denture - maxillary	30.00
D5422	Adjust partial denture - mandibular	30.00
D5510	Repair broken complete denture base	*30.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	*30.00
D5610	Repair resin denture base	*35.00
D5620	Repair cast framework	*35.00
D5630	Repair or replace broken clasp	*30.00
D5640	Replace broken teeth - per tooth	*30.00
D5650	Add tooth to existing partial denture	*30.00
D5660	Add clasp to existing partial denture	*35.00
D5710	Rebase complete maxillary denture	225.00
D5711	Rebase complete mandibular denture	225.00
D5720	Rebase maxillary partial denture	225.00
D5721	Rebase mandibular partial denture	225.00
D5730	Reline complete maxillary denture (chairside)	125.00
D5731	Reline complete mandibular denture (chairside)	125.00
D5740	Reline maxillary partial denture (chairside)	125.00
D5741	Reline mandibular partial denture (chairside)	125.00
D5750	Reline complete maxillary denture (laboratory)	200.00
D5751	Reline complete mandibular denture (laboratory)	200.00
D5760	Reline maxillary partial denture (laboratory)	200.00
D5761	Reline mandibular partial denture (laboratory)	200.00
D5810	Interim complete denture (maxillary)	275.00

Code	Service	Copayment
D5811	Interim complete denture (mandibular)	275.00
D5820	Interim partial denture (maxillary)	135.00
D5821	Interim partial denture (mandibular)	135.00
D5850	Tissue conditioning, maxillary	40.00

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Fixed prosthodontics

D6205	Pontic - indirect resin based composite	240.00
D6210	Pontic - cast high noble metal	*400.00
D6211	Pontic - cast predominantly base metal	*400.00
D6212	Pontic - cast noble metal	*400.00
D6214	Pontic - titanium	*400.00
D6240	Pontic - porcelain fused to high noble metal	*400.00
D6241	Pontic - porcelain fused to predominantly base metal	*400.00
D6242	Pontic - porcelain fused to noble metal	*400.00
D6245	Pontic - porcelain/ceramic	*400.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis	310.00
D6600	Inlay - porcelain/ceramic, two surfaces	*360.00
D6601	Inlay - porcelain/ceramic, three or more surfaces	*400.00
D6602	Inlay - cast high noble metal, two surfaces	*360.00
D6603	Inlay - cast high noble metal, three or more surfaces	*400.00
D6604	Inlay - cast predominantly base metal, two surfaces	*360.00
D6605	Inlay - cast predominantly base metal, three or more surfaces	*400.00
D6606	Inlay - cast noble metal, two surfaces	*360.00
D6607	Inlay - cast noble metal, three or more surfaces	*400.00
D6608	Onlay - porcelain/ceramic, two surfaces	*360.00
D6609	Onlay - porcelain/ceramic, three or more surfaces	*400.00
D6610	Onlay - cast high noble metal, two surfaces	*360.00
D6611	Onlay - cast high noble metal, three or more surfaces	*400.00
D6612	Onlay - cast predominantly base metal, two surfaces	*360.00
D6613	Onlay - cast predominantly base metal, three or more surfaces	*400.00
D6614	Onlay - cast noble metal, two surfaces	*360.00
D6615	Onlay - cast noble metal, three or more surfaces	*400.00
D6624	Inlay - titanium	*400.00
D6634	Onlay - titanium	*400.00
D6710	Crown - indirect resin based composite	*400.00
D6740	Crown - porcelain/ceramic	*400.00
D6750	Crown - porcelain fused to high noble metal	*400.00
D6751	Crown - porcelain fused to predominantly base metal	*400.00
D6752	Crown - porcelain fused to noble metal	*400.00
D6780	Crown - 3/4 cast high noble metal	*400.00
D6781	Crown - 3/4 cast predominantly base metal	*400.00
D6782	Crown - 3/4 cast noble metal	*400.00
D6783	Crown - 3/4 porcelain/ceramic	*400.00
D6790	Crown - full cast high noble metal	*400.00
D6791	Crown - full cast predominantly base metal	*400.00
D6792	Crown - full cast noble metal	*400.00
D6794	Crown - titanium	*400.00
D6930	Recement fixed partial denture	30.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	*100.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	100.00
D6973	Core build up for retainer, including any pins	95.00

** Patient is responsible for the cost of any laboratory charges*

Oral surgery

D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	60.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone	135.00

Code	Service	Copayment
D7220	Removal or impacted tooth - soft tissue	150.00
D7230	Removal of impacted tooth - partially bony	180.00
D7240	Removal of impacted tooth - completely bony	215.00
D7280	Surgical access of an unerupted tooth	125.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	110.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	140.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	80.00
D7510	Incision and drainage of abscess - intraoral soft tissue	90.00

Other services

General anesthesia is covered solely for dependent children under the age of 7, or the physically disabled, and only when medically necessary and in conjunction with a covered dental procedure performed at a participating dentist. General anesthesia may not be offered at all offices.

D9110	Palliative (emergency) treatment of dental pain - minor procedure	30.00
D9215	Local anesthesia	None
D9220	Deep Sedation / general anesthesia - first 30 minutes	300.00
D9221	Deep Sedation / general anesthesia - each additional 15 minutes	100.00
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	20.00
D9440	Office visit - after regularly scheduled hours	40.00
D9940	Occlusal guard, by report	*175.00

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Orthodontics

When performed by a Dental Health Services participating orthodontist.

Consultation - credited if treatment commences	40.00
Child or adult conventional 24-month treatment - excluding x-rays and models (additional charges apply for more extensive treatment)	3377.00
Retention - functional appliance	315.00

Cosmetic services

Non-covered cosmetic services, such as teeth whitening, bonding and veneers are offered by participating dentists at a 15% discount.

Covered denturist services

When performed by a Dental Health Services participating denturist.

Plastic teeth are a covered benefit. Patient is responsible for the cost of upgrades to teeth or dentures, at a 20% discount off of the participating denturist's usual and customary fees.

D5110	Complete denture - maxillary	525.00
D5120	Complete denture - mandibular	525.00
D5130	Immediate denture - maxillary	540.00
D5140	Immediate denture - mandibular	540.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	575.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	575.00
D5410	Adjust complete denture - maxillary	20.00
D5411	Adjust complete denture - mandibular	20.00
D5421	Adjust partial denture - maxillary	20.00
D5422	Adjust partial denture - mandibular	20.00
D5510	Repair broken complete denture base	50.00
D5520	Replace missing or broken teeth - complete denture	

Code	Service	Copayment
	(each tooth)	50.00
D5610	Repair resin denture base	60.00
D5620	Repair cast framework	60.00
D5630	Repair or replace broken clasp	55.00
D5640	Replace broken teeth - per tooth	55.00
D5650	Add tooth to existing partial denture	55.00
D5660	Add clasp to existing partial denture	85.00
D5710	Rebase complete maxillary denture	195.00
D5711	Rebase complete mandibular denture	195.00
D5720	Rebase maxillary partial denture	195.00
D5721	Rebase mandibular partial denture	195.00
D5730	Reline complete maxillary denture (chairside)	110.00
D5731	Reline complete mandibular denture (chairside)	110.00
D5740	Reline maxillary partial denture (chairside)	110.00
D5741	Reline mandibular partial denture (chairside)	110.00
D5750	Reline complete maxillary denture (laboratory)	170.00
D5751	Reline complete mandibular denture (laboratory)	170.00
D5760	Reline maxillary partial denture (laboratory)	170.00
D5761	Reline mandibular partial denture (laboratory)	170.00
D5810	Interim complete denture (maxillary)	270.00
D5811	Interim complete denture (mandibular)	270.00
D5820	Interim partial denture (maxillary)	135.00
D5821	Interim partial denture (mandibular)	135.00
D5850	Tissue conditioning	40.00
	Denture cleaning	5.00

Dental limitations

The following are limitations on covered benefits

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

- E. Optional service (all cases in which the enrollee selects a plan of treatment that is considered unnecessary by the provider) is charged to the enrollee at fee-for-service rates.
- F. Cosmetic dentistry – services for appearance only are at a discount off of full fees. This includes the replacement of clinically acceptable amalgam fillings, veneers, bonding and teeth whitening.
- G. Unsatisfactory patient-doctor relationship: Dental Health Services providers reserve the right to limit or deny services to an enrollee who fails to follow the prescribed course of treatment, repeatedly fails to keep appointments, fails to pay applicable copayments, is abusive to the participating provider or their staff, or obtains services by fraud or deception.
- H. Submit claims within 60 days. Dental Health Services shall not be liable to pay a claim for emergency care or for any Dental Health Services authorized treatment provided by a dentist other than a participating provider unless the enrollee submits the claim to Dental Health Services within 60 days after treatment.
- I. Denturist benefit subject to existence and availability of a licensed denturist within a 30 mile radius. Enrollees may elect to travel to the nearest participating denturist for services.
- J. Third molars (wisdom teeth) – complicated extractions of third molars are at the discretion of the general dentist and are often referred to oral surgeons (specialist). Treatment at a specialist is not covered, but may be available at a discount.
- K. Root canals – complicated root canal treatment, including calcified roots are at the discretion of the general dentist and are often referred to endodontists (specialist). Retreatment of a previous root canal is not covered. Treatment at a specialist is not covered, but may be available at a discount.
- L. Not all participating dentists can perform all dental procedures, please verify what services your selected provider can perform for you.
- M. General Anesthesia is covered solely for dependent children under the age of seven (7) or the physically or developmentally disabled, only when medically necessary and in conjunction with a covered dental procedure performed at a participating provider.
- N. All dental services not specifically listed on the *Schedule of Covered Services and Copayments* (Appendix A) are available at “usual and customary” fees when offered by a participating plan dentist.

Dental exclusions

The following are not covered by your dental plan

- A. Services not specifically covered in the “Schedule of Covered Services and Copayments.”
- B. Work in progress – dental work in progress (non-emergency/temporary procedures started but not finished prior to the date of eligibility) is not covered. This includes crown preps prepared and temporized but not cemented, root canals in mid-treatment, prosthetic cases post final impression stage (sent to the lab), etc.. This does not include teeth slated for root canal treatment and/or canals filled during an emergency visit.
- C. Services that in the opinion of the attending dentist are not necessary for the patient’s health. Extractions of non-pathologic, asymptomatic (healthy or non-symptomatic) teeth including extractions for orthodontic reasons.
- D. Implants – services for or attachments to implants.
- E. Dispensing of drugs not normally supplied in a dental office and prescriptions.
- F. Any dental procedure or service rendered while a patient is hospitalized or not in the dental office.
- G. Temporomandibular joint (TMJ) disorders and related disease including myofunctional therapy. Procedures for training, treating or developing muscles in and around the jaw of the mouth (unless provided by a separate, supplemental Dental Health Services program.)
- H. Treatment for malignancies or neoplasms (tumors).
- I. Procedures or charges for services prior to the date the enrollee became eligible for benefits under this plan, or re-treatment of these procedures

- within one (1) year of completion or charges incurred following termination of benefits under this plan.
- J. Any dental procedure that cannot be performed in the dental office due to the general health and/or physical limitations of the enrollee.
- K. Procedures, appliances or restorations other than fillings that are necessary to alter, restore or maintain occlusion, or are necessary for full-mouth rehabilitation, e.g., night guards, occlusal adjustments.
- L. Orthognathic treatment – surgical procedures and other treatment to correct the malposition of the maxilla and/or the mandible.
- M. Full mouth rehabilitation or reconstruction is not a covered benefit. Fixed restorative procedures requiring extensive restorative treatment involving more than 10 crowns (onlays, crowns, pontics) and/or an increase or decrease of the arch horizontal or vertical dimension are considered full mouth rehabilitation. Correction of malocclusion, gnathological recordings, full mouth equilibration, periodontal splinting, temporary processed functional crowns/appliances and realignment of teeth are not covered. Crowns diagnosed for cosmetic reasons only are not to be included in the determination of the full mouth rehabilitation exclusion. More than 10 crowns in a 12 month period are not covered.
- N. 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.)
- O. Replacement or stabilization of tooth structure lost through attrition, abrasion or erosion.
- P. Procedures performed by a prosthodontist.
- Q. Specialty Services requiring any referral to a specialist.

Orthodontic limitations

The following are limitations on covered benefits

- A. Cephalometric x-rays, dental x-rays.
- B. Tracings and photographs.
- C. Study models.
- D. Changes in treatment necessitated by accident of any kind.
- E. Services which are compensable under Worker’s Compensation or employer liability laws.
- F. 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. Replacement of lost or broken appliances.
- B. Retreatment of orthodontic cases.
- C. Treatment of a case in progress at inception of eligibility.
- D. Surgical procedures (including extraction of teeth) incidental to orthodontic treatment.
- E. Treatment and/or surgical procedures related to cleft palate, micrognathia or microdontia.
- F. Treatment related to temporomandibular joint disturbances and/or hormonal imbalances.
- G. 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.
- H. Payment by Dental Health Services or any special discounted orthodontic copayment for treatment rendered or required after enrollee 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.