MIB

SBHIS
INSURANCE SERVICES

PLAN W

ENGLISH

PLAN W—COPAYMENT SCHEDULE

ADA CODE	PROCEDURE DESCRIPTION	COPAYMENT

THE BENEFITS BELOW CAN ONLY BE USED AT A WESTERN DENTAL CENTER

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Listed referable procedures, that are not available in the contract facility or that require a Dentist to provide specialized services, may be provided by a contracted oral surgeon, endodontist, periodontist at 75 percent of the Contract Specialist's usual fees. Member may receive services by a contracted Western Dental oral surgeon, endodontist, periodontist at 50 percent of the Contracted Western Dental Specialist's usual fees. Specialist services are only available in areas where there is a Contract Specialist, and upon referral by the assigned Contract Dentist.

	Clinical Oral Evaluations	
D0120	Periodic oral examination - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$0
D0171	Re-evaluation - post operative office visit	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0190	Screening of a patient	$0
D0191	Assessment of a patient	$0
	Radiographs/Diagnostic Imaging (including interpretation)	
D0210	Intraoral - complete series (including bitewings)	$0
D0220	Intraoral - periapical first film	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal film	$0
D0250	Extra-oral single film	$0
D0251	Extra-oral posterior dental radiographic image	$0
D0260	Extra-oral each additional film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0273	Bitewings - three films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings - 7 to 8 films	$0

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D0330	Panoramic film	$0
D0340	Cephalometric Film	$0
D0350	Oral/Facial Images	$0
	Test and Examinations	
D0460	Pulp vitality tests	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment and documentation, with a find of high risk	$0
D0999	Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other)	$0
	Dental Prophylaxis	
D1110	Prophylaxis - adult	$0
	D1110 additional prophy exceeding two in a 12 month period	$0
D1208	Topical application of fluoride - excluding varnish - *1 D1206 or D1208 per 6 month period*	$5
D1310	Nutritional Counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1999	Unspecified Preventive Procedure, by report	$0
	Amalgam restorations (including polishing)	
D2140	Amalgam - one surface, primary or permanent	$10
D2150	Amalgam - two surfaces, primary or permanent	$20
D2160	Amalgam - three surfaces, primary or permanent	$20
D2161	Amalgam - four or more surfaces, primary or permanent	$30
	Resin - Based Composite Restorations - Direct	
D2330	Resin-based composite - one surface, anterior	$20
D2331	Resin-based composite - two surfaces, anterior	$40
D2332	Resin-based composite - three surfaces, anterior	$45
D2335	Resin-based composite - four or more surfaces or involving	$50

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D2390	Resin-based composite crown, anterior	$60
D2391	Resin-based composite - one surface, posterior	$50
D2392	Resin-based composite - two surfaces, posterior	$55
D2393	Resin-based composite - three surfaces, posterior	$60
D2394	Resin-based composite - four or more surfaces, posterior	$70
	Crowns - Single Restorations Only	
D2710	Crown - resin-based composite (indirect)	$220
D2712	Crown - 3/4 resin-based composite (indirect)	$220
D2720 ◆	Crown - resin with high noble metal	$320
D2721	Crown - resin with predominantly base metal	$320
D2722 ◆	Crown - resin with noble metal	$300
D2740	Crown - porcelain/ceramic	$300
D2750 ◆	Crown - porcelain fused to high noble metal	$300
D2751	Crown - porcelain fused to predominantly base metal	$300
D2752 ◆	Crown - porcelain fused to noble metal	$300
D2780 ◆	Crown - 3/4 cast high noble metal	$300
D2781	Crown - 3/4 cast predominantly base metal	$300
D2782 ◆	Crown - 3/4 cast noble metal	$300
D2783	Crown - 3/4 porcelain/ceramic	$310
D2790 ◆	Crown - full cast high noble metal	$300
D2791	Crown - full cast predominantly base metal	$300
D2792 ◆	Crown - full cast noble metal	$300
D2794 ◆	Crown - full cast noble metal	$300
	Other Restorative Services	
D2910	Recement inlay, onlay, or partial coverage restoration	$15
D2915	Recement cast or prefabricated post and core	$15
D2920	Recement crown	$15
D2931	Stainless Steel Crown (Permanent Teeth)	$60
D2932	Prefabricated Resin Crown	$60
D2933	Prefab Stainless Steel Crown w/Resin Window	$80
D2940	Sedative filling	$0
D2941	Interim Therapeutic Restoration - Primary Dentition	$0

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D2950	Core buildup, involving and including any pins	$40
D2951	Pin retention - per tooth, in addition to restoration	$10
D2952	Post and core in addition to crown, indirectly fabricated	$40
D2953	Each additional indirectly fabricated post - same tooth	$60
D2954	Prefabricated post and core in addition to crown	$60
D2955	Post removal (not in conjunction with endodontic therapy)	$0
D2957	Each additional prefabricated post - same tooth	$0
D2962	Labial veneer - porcelain laminate (laboratory)	$300
D2970	Temporary Crown (Fractured Tooth)	$30
D2971	Additional procedures to construct new crown under existing partial denture framework	$30
D2980	Crown repair	$60
D2999	Unspecified Restorative Procedure	$40
	Pulp Capping	
D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
	Endodontic Therapy (including treatment plan, clinical procedures & follow-up care)	
D3310	Anterior (excluding final restoration)	$100
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$200
D3330	Endodontice therapy, molar tooth (excluding final restoration)	$290
D3331	Treatment of RCT Obstruction- Non Surgical (with report)	$65
D3333	Internal Root Repair of Perforation Defects (with report)	$0
	Endodontic Retreatment	
D3346	Retreatment of previous root canal therapy - anterior	$195
D3347	Retreatment of previous root canal therapy - premolar	$200
D3348	Retreatment of previous root canal therapy - molar	$350
D3351	Apexification/Recalcification – Initial Visit	$95
D3352	Apexification/Recalcification – Interim Medication Replacement	$95
	Apicoectomy / Periradicular Services	
D3410	Apicoectomy- anterior	$190
D3421	Apicoectomy premolar (first root)	$190
D3425	Apicoectomy/periradicular surgery - molar (first root)	$190

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D3426	Apicoectomy (each additional root)	$80
D3427	Periradicular Surgery without apicoectomy	$290
D3430	Retrograde filling - per root	$0
D3450	Root amputation - per root	$0
	Other Endodontic Procedures	
D3910	Surgical procedure for isolation of tooth with rubber dam	$0
D3920	Hemisection (including any root removal), not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$0
	Surgical Services (including usual postoperative care)	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$80
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$45
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$120
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$280
D4249	Clinical crown lengthening - hard tissue	$180
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$400
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$390
D4263	Bone replacement graft - first site in quadrant	$290
D4264	Bone replacement graft – each additional site in quadrant	$160
D4265	Biologic Materials to Aid in Soft & Osseous Tissue Regeneration	$40
	Non-Surgical Periodontal Services	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$160

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ADA CODE	PROCEDURE DESCRIPTION	COPAYMENT
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis on a subsequent visit	$60
	Other Periodontal Services	
D4910	Periodontal maintenance	$80
D4921	Gingival Irrigation - Per Quadrant	$60
D4999	Irrigation – per Quad	$40
	Complete Dentures (including routine post- delivery care)	
D5110	Complete denture - maxillary	$380
D5120	Complete denture - mandibular	$380
D5130	Immediate denture - maxillary	$420
D5140	Immediate denture - mandibular	$420
	Partial Dentures (including routine - post delivery care)	
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$360
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$360
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$460
D5214	Mandibular partial denture - cast metal frameworkdenture bases (including any conventional clasps, rests and teeth)	$460
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$460
D5222	Immediate mandibular partial denture- resin base (including any conventional clasps, rests and teeth)	$460
D5223	Immediate maxillary partial denture - cast metal frame- work with resin denture bases (including any conventional clasps)	$450
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$450
D5225	Maxillary partial denture- flexible base (including any clasp, rest and teeth	$480
D5226	Mandibular partial denture - flexible base (including any clasp, rest and teeth)	$480
	Adjustments to Dentures	
D5410	Adjust complete denture - maxillary	$30

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ADA CODE	PROCEDURE DESCRIPTION	COPAYMENT
D5411	Adjust complete denture - mandibular	$30
D5421	Adjust partial denture - maxillary	$30
D5422	Adjust partial denture - mandibular	$30
	Repairs to Complete Dentures	
D5511	Repair broken complete denture base, mandibular	$60
D5512	Repair broken complete denture base, maxillary	$60
D5520	Replace missing or broken teeth - complete denture (each tooth)	$60
	Repairs to Partial Dentures	
D5611	Repair resin partial denture base, mandibular	$60
D5612	Repair resin partial denture base, maxillary	$60
D5621	Repair cast partial framework, mandibular	$60
D5622	Repair cast partial framework, maxillary	$60
D5630	Repair or replace broken clasp- per tooth	$60
D5640	Replace broken teeth - per tooth	$60
D5650	Add tooth to existing partial denture	$60
D5660	Add clasp to existing partial denture - per tooth	$60
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$180
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$180
	Denture Rebase Procedures	
D5710	Rebase complete maxillary denture	$110
D5711	Rebase complete mandibular denture	$110
D5720	Rebase maxillary partial denture	$110
D5721	Rebase mandibular partial denture	$110
	Denture Reline Procedures	
D5730	Reline complete maxillary denture (chairside)	$60
D5731	Reline complete mandibular denture (chairside)	$60
D5740	Reline maxillary partial denture (chairside)	$60
D5741	Reline mandibular partial denture (chairside)	$60
D5750	Reline complete maxillary denture (laboratory)	$110
D5751	Reline complete mandibular denture (laboratory)	$110
D5760	Reline maxillary partial denture (laboratory)	$110
D5761	Reline mandibular partial denture (laboratory)	$110

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ADA CODE	PROCEDURE DESCRIPTION	COPAYMENT
	Other Removable Prosthetic Services	
D5810	Interim complete denture (maxillary)	$300
D5811	Interim complete denture (mandibular)	$300
D5820	Interim partial denture (maxillary)	$250
D5821	Interim partial denture (mandibular)	$250
D5850	Tissue conditioning, maxillary	$80
D5851	Tissue conditioning, mandibular	$80
D5862	Precision Attachment – By Report	$10
D5863	Overdenture complete maxillary	$450
D5865	Overdenture complete mandibular	$450
D5982	Surgical Stent	$130
	Fixed Partial Denture Pontics	
D6010	Surgical placement of implant body: endosteal implant	$1690
D6058	Abutment supported porcelain/ceramic crown	$960
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$965
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$915
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$930
D6062	Abutment supported cast metal crown (high noble metal)	$925
D6063	Abutment supported cast metal crown (predominantly base metal)	$800
D6064	Abutment supported cast metal crown (noble metal)	$840
D6065	Implant supported porcelain/ceramic crown	$955
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$935
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$910
D6068	Abutment supported retainer for porcelain/ceramic FPD	$910
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$965
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$915

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ADA CODE		PROCEDURE DESCRIPTION	COPAYMENT
D6071		Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$930
D6072		Abutment supported retainer for cast metal FPD (high noble metal)	$950
D6073		Abutment supported retainer for cast metal FPD (predominantly base metal)	$860
D6074		Abutment supported retainer for cast metal FPD (noble metal)	$925
D6081		Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the im- plant surfaces, without flap entry and closure	$30
D6194		Abutment supported retainer crown for FPD (titanium)	$500
D6205		Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	$220
D6210	◆	Pontic - cast high noble metal	$395
D6211		Pontic - cast predominantly base metal	$350
D6212	◆	Pontic - cast noble metal	$350
D6214		Pontic - titanium	$385
D6240		Pontic - porcelain fused to high noble metal	$385
D6241		Pontic - porcelain fused to predominantly base metal	$350
D6242	◆	Pontic - porcelain fused to noble metal	$350
D6245		Pontic - porcelain/ceramic	$450
D6250		Pontic - resin with high noble metal	$350
D6251		Pontic - resin with predominantly base metal	$350
D6252	◆	Pontic - resin with noble metal	$350
		Fixed Partial Denture Retainers—Inlays/Onlays	
D6545		Retainer - cast metal for resin bonded fixed prosthesis	$220
		Fixed Partial Denture Retainers—Crowns	
D6710		Crown - indirect resin based composite	$220
D6720	◆	Crown - resin with high noble metal	$350
D6721		Crown - resin with predominantly base metal	$350
D6722	◆	Crown - resin with noble metal	$350
D6740		Crown - porcelain/ceramic	$490
D6750	◆	Crown - porcelain fused to high noble metal	$350

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ADA CODE		PROCEDURE DESCRIPTION	COPAYMENT
D6751		Crown - porcelain fused to predominantly base metal	$350
D6752	◆	Crown - porcelain fused to noble metal	$350
D6780	◆	Crown - 3/4 cast high noble metal	$350
D6781		Crown - 3/4 cast predominantly base metal	$350
D6782	◆	Crown - 3/4 cast noble metal	$350
D6783		Crown - 3/4 cast porcelain/ceramic	$450
D6790		Crown - full cast high noble metal	$450
D6791		Crown - full cast predominantly base metal	$350
D6792		Crown - full cast noble metal	$350
		Other Fixed Partial Denture Services	
D6930		Recement fixed partial denture	$0
D6940		Stress breaker	$150
D6980		Fixed partial denture repair, by report	$10
		Extractions (includes local anesthesia, suturing if needed, and routine postoperative care)	
D7111		Extraction, coronal remnants - primary tooth	$55
D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$80
		Surgical Extractions (includes local anesthesia, suturing if needed, and routine postoperative care)	
D7210		Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$50
D7220		Removal of impacted tooth - soft tissue	$150
D7230		Removal of impacted tooth - partially bony	$190
D7240		Removal of impacted tooth - completely bony	$290
D7241		Removal of impacted tooth - completely bony, with unusual surgical complications	$290
D7250		Surgical removal of residual tooth roots (cutting procedure)	$150
D7270		Tooth reimplantation and/or stabilization	$175
D7280		Surgical access of an unerupted tooth	$50
D7283		Placement of device to facilitate eruption of impacted tooth	$90
D7285		Biopsy – Hard Tissue	$80
D7286		Biopsy – Soft Tissue	$25

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D7310	Alveoloplasty with extractions – (4 or more teeth or tooth spaces, per quadrant)	$40
D7311	Alveoloplasty without extractions – (1-3 teeth per quadrant)	$90
D7320	Alveoloplasty without extractions – (4 or more teeth or tooth spaces, per quadrant)	$90
D7321	Alveoloplasty without extractions – (1-3 teeth or tooth spaces, per quadrant)	$90
D7340	Vestibuloplasty – Ridge Extension (Secondary Epitheliazation)	$195
D7350	Vestibuloplasty – Ridge Extension	$480
D7410	Excision of Benign Lesion (up to 1.25 cm)	$80
	Surgical Incision	
D7510	Incision and drainage of abscess – intraoral soft tissue	$60
D7511	Incision & Drainage of abscess - intraoral soft tissue	$60
D7520	Incision and drainage of abscess – extraoral soft tissue	$90
D7521	Incision and drainage of abscess – extraoral – complicated	$115
	Other Repair Procedures	
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$80
D7963	Frenuloplasty	$40
D7970	Excision of hyperplastic tissue - per arch	$115
D7971	Excision of pericoronal gingiva	$55
	Unclassified Treatment	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$20
	Anesthesia	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	$200
D9223	Deep Sedation/General Anesthesia - Each Subsequent 15 Minute increment	$160

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ADA CODE	PROCEDURE DESCRIPTION	COPAYMENT
	Professional Consultation	
D9310	Consultation - (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0
D9311	Consultation with medical heath care professional	$0
	Professional Visits	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit, after regularly scheduled hours	$70
D9450	Case presentation, detailed and extensive treatment planning	$0
	Miscellaneous Services	
D9910	Application of desensitizing medicament	$20
D9932	Cleaning and inspection of removable complete denture, maxillary	$20
D9933	Cleaning and inspection of removable complete denture, mandibular	$20
D9934	Cleaning and inspection of removable partial denture maxillary	$20
D9935	Cleaning and inspection of removable partial denture, mandibular	$20
D9940	Occlusal guard, by report	$215
D9951	Occlusal adjustment - limited	$30
D9952	Occlusal adjustment - complete	$110
D9972	External bleaching - per arch - take home trays	$80
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$130
	Non-Clinical Procedures	
D9987	Cancelled appointment (24 Hour Notice)	$0
D9995	Teledentistry – synchronous; real time encounter	$0
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$0

Footnotes

◆ Metal charges apply to a maximum of $125

LIMITATIONS & EXCLUSIONS

LIMITATIONS

The following Limitations apply to Services Covered in the Schedule of Benefits.

Diagnostic

Full Mouth X-Ray, Panoramic Film, Cephalometric Film, and Oral/Facial Images - once in a two-year period.

Coverage for bitewing X-rays - no more than one series of four (4) films in any six-month period.

Preventive

Prophylaxis covered twice in twelve (12) months. Examples of situations where an additional prophylaxis within the twelve (12) month period may be necessary for the dental health of the Member and may be covered are:

1) Pregnancy
2) Pre-radiation therapy as ordered by an oncologist
3) Gingival hyperplasia due to the use of Dilantin or other medications
4) Inflammation due to syphilis or tuberculosis
5) Chronic menopausal gingivostomatitis
6) Leukemia or HIV induced gingivitis

Fluoride Treatments (Topical Application and Fluoride Varnish).

Topical Fluoride Treatments are limited to two (2) treatments in a 12 consecutive month period.

Restorative Services

Crowns, Inlays and Onlays

Will be covered when a filling cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental care. (Example: buccal or lingual walls are either fractured or decayed to the extent that the tooth cannot hold a filling).

Use of precious metal in fabrication of a crown, inlay or onlay is considered elective and an additional metal charge will apply.

Endodontics

Endodontic Re-treatments (ADA Codes D3346, D3347 and D3348) are limited to one per tooth per lifetime.

Apicoectomies (ADA Codes D3410, D3421, D3425 and D3426) are limited to one per root per lifetime.

Periodontics

Scaling and Root Planing (per quadrant) and Full Mouth Debridement are covered once every twelve months.

Crown lengthening (ADA Code D4249) is limited to one (1) per tooth per lifetime.

Complete and Partial Dentures

Replacement of an existing appliance will be covered if the appliance is over five years old and cannot be made serviceable by reline, rebase or repair.

Tooth Additions and Repair to Existing Denture, Repair of appliances damaged due to Member abuse, Denture Reline and Rebase and Relines of full or partial dentures are limited to twice in a calendar year.

Fixed Bridge(s), Pontics, and Crowns

Replacement of an existing appliance will be covered if the appliance is over five years old, is defective and cannot be made serviceable.

Fixed bridges are a covered benefit when a removable partial denture cannot satisfactorily restore the case in accordance with professionally recognized standards of dental practice.

If the Member elects a fixed bridge instead of the covered removable partial denture, the Member's benefit for the partial denture will be applied to the Member's cost for the fixed bridge as follows:

Copayment for the fixed bridge = UCR Cost of the Fixed Bridge – UCR Cost of the Removable Partial Denture + the Copayment of the Removable Partial Denture.

If the Member has unreplaced missing teeth on opposite sides of the same arch, a removable partial denture is considered the covered benefit.

The Plan provides coverage for up to six units of crown and/or fixed bridges in the same treatment plan.

Each tooth treated with a crown and replaced tooth in a fixed bridge ("pontic") included in the treatment plan is referred to as a "unit". When a treatment plan consists of more than six units of crowns and/or bridges, the term "full mouth reconstruction" is used to describe the treatment plan, and units in excess of six are not a Covered Service, and the Member will be charged at the Participating Provider's usual and customary rate.

Pediatric Dentistry Referrals

Referral for pediatric dentistry services for children under the age of six years must be pre-authorized by the Plan. Exceptions for physical or mental handicaps or medically compromised individuals, when confirmed by the treating physician, may be considered on an individual basis with prior approval from the Plan.

Limitations apply unless the treating Participating Provider can document that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice, at which point such services will be covered as set forth in the accompanying Schedule of Benefits.

EXCLUSIONS

The following dental procedures and services are excluded from this coverage:

Preventive

Supplies used for oral hygiene, plaque control, oral physiotherapy instruction, and chemical analysis of saliva.

Restorative Services Crowns, Inlays and Onlays

Crowns, inlays or onlays that are only for cosmetic purposes.

Crowns, inlays or onlays that are lost, stolen, or damaged due to Member abuse, misuse or neglect. Crowns and pontics supported on a dental implant.

Charges for specialized techniques involving precision attachments, and personalization or characterization of such appliances.

Periodontics

Soft Tissue Grafts.

Complete and Partial Dentures

Replacement or repair of a lost, stolen, or damaged appliance due to Member abuse.

Removable Prosthetic Services and supplies that are only for cosmetic purposes.

Implant supported dentures, unless specifically listed as a covered benefit under your plan.

Fixed Bridges

Replacement or repair of a lost, stolen, or damaged bridge due to Member abuse.

Distal extension posterior cantilever pontics, which are supported at the front end only.

Implant supported bridges, unless specifically listed as a covered benefit under your plan.

Oral Surgery

Removal of third molars (wisdom teeth), supernumerary teeth or other teeth that are impacted that do not have associated pathology.

Removal of teeth for orthodontic purposes only.

General Exclusions

Treatment by someone other than a Participating Provider or dental auxiliary under the direction of a Participating Provider, except for Emergency treatment as provided in the EOC (Evidence of Coverage) or upon prior authorization by the Plan.

Charges for medical treatment, prescriptions or other charges not directly related to dental services provided. Hospitalization costs for any dental procedure, including all hospital services, anesthesia and medications.

Any dental treatment that is determined by the Plan to be the responsibility of Worker's Compensation, employer, the health care plan, payable under any Federal Government or state program, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy, or for services for which benefits are payable under any other insurance.

Treatment of malignancies, neoplasms, and cysts, unless specifically listed as a Covered Service on the Schedule of Benefits.

Treatment of Myofacial pain or disturbances of the Temporomandibular Joint (TMJ), including correction of occlusion or "occlusal equilibration".

Procedures, restorations, and appliances to correct congenital or developmental malformations.

Services and supplies that are not deemed necessary for a Member's dental health in accordance with professionally recognized standards of dental practice.

Dental expenses incurred in connection with any portion of the dental services provided prior to the effective date of coverage or dental expenses incurred in connection with any dental procedure started after termination of coverage.

Services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion, including, but not limited to, full mouth rehabilitation, splinting, appliances or any other method.

Appliances to correct and control harmful habits (e.g., tongue thrust and thumb sucking).

The Plan's orthodontic benefit covers only basic orthodontic treatment to resolve malocclusion and establish optimal dental and facial esthetics. Orthodontic treatment may involve the primary, transitional or permanent dentition. All orthodontic services must be provided by a Participating Provider to be covered under the Benefit Plan. Refer to the "Orthodontics" category of your Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

ORTHODONTIC LIMITATIONS

Benefits for any phase of Orthodontic treatment are limited to a maximum of 24 months. Treatment extending beyond the 24th month may be charged a monthly continuation fee per the Member's Orthodontic contract with the provider.

ORTHODONTIC EXCLUSIONS

The following dental procedures and services are excluded from this coverage:

Special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders).

TMJ/Myofunctional Therapy – Therapy for treatment of jaw joint problems, and teaching and therapy for improper swallowing and tongue posture.

Surgical Orthodontics – Orthodontic treatment in conjunction with Orthognathic surgery.

Orthognathic Surgery – Surgery to move the jaw bones into alignment.

Treatment of Cleft Palate – Treatment for problems involving holes or voids in the bone that forms the roof of the mouth.

Removable Orthodontic Appliance Therapy – The use of appliances that are removable from the mouth by the Member and which are used to hold or move and align teeth.

Treatment of Hormonal Imbalances – The treatment of hormone imbalances that influence growth and influence the ability of teeth to move without root damage.

Orthodontic Treatment Commenced Prior to Coverage – An orthodontic treatment program which commenced before the Member enrolled in this Benefit Plan.

Retreatment of Orthodontic Cases – The treatment of orthodontic problems that have been treated before.

Repair or replacement of lost, stolen, damaged or broken appliances, including retainers, brackets, bands, wires or other materials supplied by the orthodontist.

Extractions for Orthodontic Purposes – Removal of teeth specifically to correct orthodontic problems or due to lack of eruptive space are not covered.

Post-treatment Records - X-rays, photographs and models following orthodontic treatment.

NOTE: THIS IS ONLY A BRIEF SUMMARY OF THE PLAN

The Group Dental Service Contract must be consulted to determine the exact terms and conditions of coverage. An Evidence of Coverage will be sent to you upon enrollment.

If you wish to review an Evidence of Coverage prior to enrollment, you may request a copy by calling the Member Services Department at (800) 687-9937

530 South Main Street

Orange, CA 92868

Member Services: 800-687-9937

FSC-PLAN W (03/21)