# Dental Source

## Dental Health Care Plans
## Schedule of Benefits – Plan H

The American Dental Association (ADA) assigns code numbers to each dental service. The Schedule of Services below provides you with an easy reference to the coverage associated with the Dental Source Program. All copayments are paid directly to your selected participating general dentist and are due at the time of service. All dental services listed in this schedule are provided **exclusively** by Dental Source network general dentists. There is no coverage outside of the Dental Source network. If the services of a Specialist are required, the member will receive a 20% discount off the usual fees from a participating Specialist, where available.

| ADA CODE | PROCEDURE | Co-payment |
|---|---|---|
| **Diagnostic and Preventive – General Dentists Office** | | |
| **** | Consultation | No Charge |
| 0120 | Periodic Oral Examination | No Charge |
| 0140 | Limited Oral Evaluation-Problem Focused (Normal Office Hours) | 20.00 |
| 0150 | Comprehensive Oral Evaluation | No Charge |
| 0210 | Full Mouth X-Ray | 15.00 |
| 0220 | Initial Periapical X-Ray | No Charge |
| 0230 | Additional Periapical X-Ray | No Charge |
| 0240 | Occlusal X-Ray | No Charge |
| 0250 | Extraoral X-Ray | No Charge |
| 0270-0274 | Bitewing X-Ray | No Charge |
| 0330 | Panoramic X-Ray | 15.00 |
| 0460 | Tooth Pulp Vitality Test | No Charge |
| 0470 | Diagnostic Casts - Study Models | No Charge |
| 1110 | Prophylaxis-Adult-Every 6 Months | No Charge |
| 1120 | Prophylaxis-Child-Every 6 Months | No Charge |
| 1203 | Topical Application of Fluoride-Child- Through age 18 Every 6 Months | No Charge |
| 1204 | Topical Application of Fluoride- Adult- Every 6 Months. | 8.00 |
| 1330 | Oral Hygiene Instruction | No Charge |
| 1351 | Sealant | 12.00 |
| 1510 | Space Maintainer-Fixed-Unilateral | 65.00 |
| 1515 | Space Maintainer-Fixed-Bilateral | 65.00 |
| 1520 | Space Maintainer-Removable-Unilateral | 80.00 |
| 1525 | Space Maintainer-Removable-Bilateral | 80.00 |
| ***** | Difficult Prophylaxis Subjected to a 25.00 Charge | |
| **Restorative (Fillings, Inlays and Onlays) - General Dentist Office** | | |
| 2140 | Amalgam-Primary, 1 Surface | 10.00 |
| 2150 | Amalgam-Primary, 2 Surfaces | 16.00 |
| 2160 | Amalgam- Primary, 3 Surfaces | 21.00 |
| 2161 | Amalgam- Primary, 4 or More Surfaces | 25.00 |
| 2140 | Amalgam-Permanent, 1 Surface | 11.00 |
| 2150 | Amalgam-Permanent, 2 Surfaces | 18.00 |
| 2160 | Amalgam- Permanent, 3 Surfaces | 23.00 |
| 2161 | Amalgam- Permanent, 4 or More Surfaces | 28.00 |
| 2210 | Silicate Cement – Per Restoration | 18.00 |
| 2330 | Resin-Based Composite 1 Surface- Anterior | 20.00 |
| 2331 | Resin-Based Composite 2 Surfaces – Anterior | 30.00 |
| 2332 | Resin-Based Composite 3 Surfaces – Anterior | 40.00 |
| 2335 | Resin-Based Composite 4 + Surfaces– Anterior (Incisal Angle) | 60.00 |
| 2390 | Resin-Based Composite Crown – Anterior | 65.00 |
| 2391 | Resin-Based Composite 1 Surface–Posterior-Primary | 21.00 |
| 2392 | Resin-Based Composite 2 Surfaces–Posterior-Primary | 24.00 |
| 2393 | Resin-Based 3 Surfaces-Posterior–Primary | 28.00 |
| 2391 | Resin-Based Composite1 Surface–Posterior-Permanent | 50.00 |
| 2392 | Resin-Based Composite 2 Surfaces –Posterior-Permanent | 55.00 |
| 2393 | Resin-Based Composite 3 Surfaces – Posterior-Permanent | 60.00 |
| 2394 | Resin-Based Composite 4 or More Surfaces – Posterior-Permanent | 85.00 |
| 2510 | Inlay-Metallic-1 –Surface | 185.00 |
| 2520 | Inlay-Metallic- 2- Surface | 210.00 |
| 2530 | Inlay-Metallic-3-Surface | 235.00 |
| 2543 | Onlay-Metallic-3 – Surface | 250.00 |
| 2544 | Onlay- Metalic-4- Surface | 265.00 |
| 2610 | Inlay-Porcelain/Ceramic1 Surface | 215.00 |
| 2620 | Inlay-Porcelain/Ceramic 2 Surfaces | 250.00 |
| 2630 | Inlay-Porcelain/Ceramic 3 or More Surfaces | 260.00 |
| 2642 | Onlay-Porcelain/Ceramic 2 Surfaces | 250.00 |
| 2643 | Onlay-Porcelain/Ceramic 3 Surfaces | 290.00 |
| 2650 | Inlay-Composite/Resin-1 Surfaces. | 150.00 |
| 2651 | Inlay-Composite/Resin-2 Surfaces | 185.00 |
| 2652 | Inlay-Compsite/Resin- 3 or More Surfaces | 225.00 |
| 2662 | Onlay Composite/Resin-2 Surfaces | 175.00 |
| 2663 | Onlay-Composite/Resin-3 Surfaces | 200.00 |
| 2664 | Onlay-Composite/Resin-4 or MoreSurfaces | 225.00 |
| 2940 | Sedative Fillings | 20.00 |
| **** | Laboratory Fees Are Not Covered. | |
| **Restorative (Crowns-Single Restorations) - General Dentist Office** | | |
| **** | Crown-Temporary in Conjunction With Permanent | No Charge |
| 2740 | Crown-Porcelain/Ceramic Substrate | 295.00 |
| 2750 | Crown-Porcelain Fused to High Noble Metal | 275.00 |
| 2751 | Crown-Porcelain Fused to Predominantly Base Metal | 275.00 |
| 2752 | Crown-Porcelain Fused to Noble Metal | 275.00 |
| 2780-83 | Crown-3/4 | 275.00 |
| 2790 | Crown-Full Cast High Noble Metal | 295.00 |
| 2791 | Crown-Full Cast Predominantly Base Metal | 275.00 |
| 2792 | Crown-Full Cast Noble Metal | 275.00 |
| 2910 | Recement Inlays | 20.00 |
| 2920 | Recement Crowns | 25.00 |
| 2930 | Stainless Steel Crown-Primary Tooth | 68.00 |
| 2950 | Crown Buildup, Including Any Pins | 75.00 |
| 2951 | Pin Retention | 18.00 |
| 2952 | Cast Post & Core in Addition to Crown | 100.00 |
| 2954 | Pre-fab Post & Core in Addition to Crown | 80.00 |
| 2960 | Labial Veneers (Chairside) | 250.00 |
| 2962 | Labial Veneer (Lab) | 300.00 |
| 2980 | Crown Repair - By Report | 25.00 |
| **** | Laboratory Fees Are Not Covered. | |
| **Endodontics (Root Canal Therapy) - General Dentist Office** | | |
| **** | Endo Consultation | No Charge |
| 3110 | Pulp Cap Direct | 15.00 |
| 3120 | PulpCap Indirect | 12.00 |
| 3220 | Vital Pulpotomy | 48.00 |
| 3310 | Root Canal-Anterior | 125.00 |
| 3320 | Root Canal-Bicuspid | 180.00 |
| 3330 | Root Canal-Molar | 250.00 |
| 3410 | Apicoectomy – Anterior | 140.00 |
| 3421 | Apicoectomy- Bicuspid-First Root | 140.00 |
| 3425 | Apicoectomy-Molar-First Root | 175.00 |
| 3426 | Apicoectomy- Each Additional Root | 80.00 |
| 3430 | Retrograde Filling-Each Root | 50.00 |
| **Periodontics - General Dentist Office** | | |
| **** | Perio Consultation | No Charge |
| 4999 | Perio Charting | 20.00 |
| 4210 | Gingivectomy or Gingivoplasty (per quadrant) | 115.00 |
| 4220 | Gingival Curettage (per quadrant) | 60.00 |
| 4240 | Gingival Flap Surgery (per quadrant) | 265.00 |
| 4260 | Osseous Surgery (per quadrant) | 300.00 |
| 4341 | Periodontal scaling & root planing (per quadrant) | 50.00 |
| 4355 | Full Mouth Debridement | 44.00 |
| 4910 | Periodontal Maintenance | 35.00 |
| **Prosthodontics (Removable) - General Dentist Office** | | |
| 5110 | Complete Dentures-Upper | 350.00 |
| 5120 | Complete Dentures-Lower | 350.00 |
| 5130 | Immediate Upper Denture (Excluding Reline) | 400.00 |
| 5140 | Immediate Lower Denture (Excluding Reline) | 400.00 |
| 5211 | Partial Denture-Upper/Resin Base | 350.00 |
| 5212 | Partial Denture-Lower/Resin Base | 350.00 |
| 5213 | Partial Denture-Upper/ Metal Base | 425.00 |
| 5214 | Partial Denture-Lower/Metal Base | 425.00 |
| 5410 | Adjust Complete Denture -Upper | 10.00 |
| 5411 | Adjust Complete Dentures-Lower | 10.00 |
| 5421 | Adjust Partial Denture-Upper | 10.00 |

| | | |
|---|---|---|
| 5422 | Adjust Partial Denture-Lower | 10.00 |
| 5510 | Repair Denture Base | 35.00 |
| 5520 | Repair/Replace Broken Tooth/Denture | 35.00 |
| 5620 | Repair Cast Framework | 35.00 |
| 5630 | Repair or Replace Broken Clasp | 35.00 |
| 5640 | Replace Broken Tooth -Per Tooth | 35.00 |
| 5650 | Add Tooth to Existing Partial | 35.00 |
| 5660 | Add Clasp To Existing Partial | 35.00 |
| 5730 | Reline Upper Dentures-Chairside | 75.00 |
| 5731 | Reline Lower Dentures-Chairside | 75.00 |
| 5740 | Reline Upper Partial-Chairside | 70.00 |
| 5741 | Reline Lower Partial-Chairside | 70.00 |
| 5750 | Reline Upper Denture-Lab | 85.00 |
| 5751 | Reline Lower Denture-Lab | 85.00 |
| 5760 | Reline Upper Partial-Lab | 85.00 |
| 5761 | Reline Lower Partial-Lab | 85.00 |
| **** | Laboratory Fees Are Not Covered. | |

**Prosthodontics - General Dentist Office**

| | | |
|---|---|---|
| 6240 | Pontic-Porcelain Fused to High Noble Metal | 275.00 |
| 6241 | Pontic-Porcelain Fused to Predominantly Base Metal | 275.00 |
| 6242 | Pontic-Porcelain Fused to Noble Metal | 275.00 |
| 6750 | Crown-Porcelain Fused to High Noble Metal | 275.00 |
| 6751 | Crown-Porcelain Fused to Predominantly Base Metal | 275.00 |
| 6752 | Crown-Porcelain Fused to Noble Metal | 275.00 |
| 6790 | Crown-Full Cast High Noble Metal | 275.00 |
| 6791 | Crown-Full Cast Predominantly Base Metal | 275.00 |
| 6792 | Crown-Full Cast Noble Metal | 275.00 |
| 6930 | Recement Bridge | 25.00 |
| 6940 | Stress Breaker | 10.00 |
| 6950 | Precision Attachment | 195.00 |
| **** | Laboratory Fees Are Not Covered. | |

**Oral Surgery - General Dentist Office**

| | | |
|---|---|---|
| **** | Oral Surgery Consultation | No Charge |
| 7111 | Extraction-Coronal Remnants-Primary | 25.00 |
| 7140 | Extraction-Erupted Tooth or Exposed Root | 25.00 |
| 7210 | Surgical Removal of Erupted Tooth | 50.00 |
| 7220 | Removal of Impacted Tooth-Soft Tissue | 70.00 |
| 7230 | Removal of Impacted Tooth-Partial Bony | 90.00 |
| 7240 | Removal of Impacted Tooth-Complete Bony | 110.00 |
| 7241 | Removal of Impacted Tooth-Complete Bony w/Comp | 175.00 |
| 7250 | Surgical Removal of Residual Roots | 90.00 |
| 7281 | Surgical Exposure of Tooth | 150.00 |
| 7310 | Alveloplasty in Conjunction w/Extractions/ Per Quadrant | 100.00 |
| 7320 | Aleveoloplasty Not in Conjunction w/Extractions/Per Quadrant | 150.00 |
| 7470 | Removal of Exostosis | 225.00 |
| 7510 | Incision & Drainage of Abscess-Intraoral Soft Tissue | 55.00 |
| 7960 | Frenectomy | 80.00 |
| **** | Post Operative Treatment (including dry socket treatment) | No Charge |

**Orthodontics (Braces) - General Dentist Office**

| | | |
|---|---|---|
| **** | Ortho Consultation (General Dentist Only) | No Charge |
| **** | Ortho Treatment Plan (Records & Models) | 75% |
| **** | Orthodontic Appliance | 75% |
| **** | Orthodontic Appliance Therapy | 75% |
| **** | Orthodontic Treatment | 75% |

**Adjunctive General Services - General Dentist Office**

| | | |
|---|---|---|
| 9215 | Local Anesthesia | No Charge |
| 9230 | Nitrous Oxide (per 15 minutes) | 10.00 |
| 9430 | Office Visit For Observation (Normal Office Hours) | No Charge |
| 9440 | Emergency office visit (After Office Hours) | 40.00 |
| 9940 | Occlusal Guards-By Report | 75.00 |
| 9951 | Occlusal Adjustment-Limited | 55.00 |
| 9952 | Occlusal Adjustment-Complete | 125.00 |
| 9999 | Broken Appointments (Per 15 Minutes Scheduled) | 10.00 |

**EMERGENCY TREATMENT COVERAGE:**

In the event of a dental emergency, Dental Source members should contact their selected Dental Source provider. If the Dental Source provider is unavailable for emergency care within 24 hours, members may obtain emergency services from any licensed dentist. The covered emergency services include palliative treatment to control pain, bleeding, or infection. Dental Source members will be reimbursed up to $50.00 based on the Dental Source Schedule of Benefits. Any further restorative service must be provided by the member's selected Dental Source provider. In order to receive reimbursement for fees paid, less any applicable co-payment, the member must notify Dental Source within two working days of the onset of the emergency, and written request for reimbursement with receipts must be received by Dental Source within 30 days of the onset of the emergency.

**EXCLUSIONS AND LIMITATIONS - GENERAL DENTIST**

1. Laboratory fees or lab related charges.
2. Prophylaxis (cleanings) and fluoride treatments are limited to one every 6 months. Difficult prophylaxis (i.e. heavy smoker, neglected teeth) are subject to a $25.00 charge.
3. Procedures provided by any dentists including specialists who are not within the Dental Source provider network.
4. Treatment provided by a participating Dental Source dentist other than your selected dentist prior to receiving approval from the Dental Source office.
5. Dental treatment commenced prior to the member's eligibility or in progress at the time of application or expenses incurred after termination from plan are not covered
6. Dental expenses incurred if a participating dentist is unable to perform a procedure due to a member's general health or physical condition (i.e. patient physically unable to visit dentist office or suffering from a contagious illness or disease).
7. Charges for broken appointments.
8. Any dental procedure not listed as a covered service including but not limited to general anesthesia, the services of an anesthesiologist, prescription medication, implants, treatment required by reason of war, hospital and medical charges of any kind, surgery of fractures and dislocations, loss or theft of dentures or bridgework, and the treatment of malignancies.
9. Services provided to the member by state government, or agencies thereof, or services provided without cost to the member by any municipality, county, or other subdivision.
10. Procedures, appliances, or restorations to correct congenital, developmental, or medically induced dental disorders, including but not limited to, treatment of myo-functional, myo-skeletal, or temporomandibular joint dysfunction (TMJ).
11. Dentures, bridges, and other appliances fabricated under this program can be replaced only once during the period of 5 years after the original insertion. A denture, bridge, or other appliance can be replaced only if it cannot be made satisfactory by reline or repair.
12. A denture, bridge, or other appliance installed while not covered by Dental Source will be replaced only if it cannot be made satisfactory by reline or repair.
13. All covered replacements are subject to the co-payment as listed in the Schedule of Benefits. Replacement of dentures, appliances or bridgework due loss or theft is not covered.
14. Crowns are covered only if the dentist determines that there is not enough retentive quality left in a tooth to hold a filling.
15. Replacement of a satisfactory filling is not covered.
16. Charges for disposable and sterilization fees.
17. Any dental procedure solely for the purpose of cosmetic reasons is not a covered benefit.
18. Sealants are covered through the age 14; replacements covered at no charge within the first twelve months of original application.
19. Failure to pay a scheduled co-payment may prevent future dental services from being received until all fees have been paid in full.
20. A dependent child shall be covered until the age of 25; if unmarried, a state resident and not covered under another benefit plan or government program.

***THIS FEE SCHEDULE IS ONLY APPLICABLE FOR THOSE SERVICES PROVIDED BY A PARTICIPATING DENTAL SOURCE GENERAL DENTIST. IF THE SERVICES OF A PARTICIPATING SPECIALIST ARE REQUIRED, MEMBERS WILL RECEIVE A DISCOUNT FROM THAT PARTICIPATING SPECIALIST.***