

Below is our standard list of covered services. This list may vary depending on the group's plan design. Coverage is subject to the patient's eligibility at the time of service.

## Preventive Services

Exams of any kind; prophys (child prophy age 14 & under; adult prophy age 15 & over); fluoride (age 14 & under)	Twice Per Year
Bitewing x-rays (age 11 & over)	8 Per Year
Occlusal x-rays (1 upper & 1 lower)	Once every 24 months
Panoramic (age 6 & over) or full mouth series x-rays (age 11 & over)	Once every 36 months

## Basic Services

Fillings on the same tooth on the same surface, other than gold fillings (composite fillings on primary posterior teeth will be reduced to an amalgam benefit)	Once every 24 months
Space maintainers, per tooth per area (age 14 & under)	Once per lifetime
Sealants (age 14 & under on permanent posterior & bicuspid teeth. Sealants are not covered on anterior teeth, previously restored teeth or if applied within 3 years of last sealant)	Once every 36 months
Endodontics* - root canal therapy, pulpotomy, apicoectomy, apexification, retro-grade fillings, retreat, pulpal therapy. Age restrictions may apply.	Once per lifetime, per tooth, per procedure
Periodontics* – root scaling / planing per quad	Once every 24 months
Periodontal maintenance* (in lieu of preventive cleaning)	Twice per year
Periodontal surgery*	Once every 36 months
<i>*Periodontics and/or Endodontics may be covered under Major, depending on group.</i>	

## Major Services

Inlays & onlays, crowns, bridges, complete or partial dentures and gold fillings, per surface per tooth (age 16 & over) (see documentation)	Once every 5 years
Occlusal guards for bruxism only	Once every 24 months
Full mouth debridement (with no history of prior cleaning; no other services except x-rays, exams D120 or D150 may be performed on the same day)	Once every 5 years
General anesthesia – age 7 & under, in conjunction with any service; age 8 & over, <b>only in conjunction with extractions of impacted teeth.</b>	\$150 maximum per year

## Orthodontic Services

Diagnostic records (cepholametric film, panoramic or full mouth x-rays, diagnostic casts, diagnostic photographs); Bill as code D8660 for diagnostic records	Children under 19, paid up to lifetime maximum. Bill quarterly or monthly
Removable, fixed or cemented appliance for orthodontic treatment including impressions, installations, & all adjustments while covered under the plan	
<i>No coverage or limited coverage for orthodontic treatment that began prior to the effective date of coverage.</i>	

## Documentation

Inlays & onlays; multiple surface composites (D2335); bridges; partials; anterior crowns; 2 or more posterior crowns with no history of build-up	Submit x-rays with claim
Scaling and root planing; periodontal maintenance; periodontal surgery	Submit periodontal charting and full mouth x-rays with claim
Wisdom teeth, impacted	Submit x-rays with claim

## No Coverage

<b>All Plans</b>	Nitrous Oxide
	Inlays & onlays or crowns on teeth that can be restored by direct placement materials
	Missing Tooth Clause – Replacement of teeth that were missing ( <b>extracted or congenitally</b> ) prior to the effective date of coverage are not eligible for 3 years from effective date of continuous coverage.
	Replacement of full or partial dentures, bridges, inlays & onlays or crowns within 5 years of placement.

## Self Funded Plans

Groups that are self-funded govern their own unique fee schedules & benefits, which may vary from Dental Select's standard plan design. Please contact Member Services for any questions regarding self-funded groups or their plan benefits.

**Below are Dental Select's most common "Remark Codes" and their corresponding descriptions. These codes are used on EOPs to convey information about remittance processing, adjustments and/or code-specific limitations. Please contact our Member Services Department at 800-999-9789 with any questions about these codes.**

Code	Message
H005	Submitted service date is invalid.
H020	Payment cannot be considered without identity and/or payment information from primary payer. Required information was either missing, incomplete, invalid or illegible. Please resubmit claim with payment/benefit information from the primary payer.
H038	Invalid procedure code.
H052	This alternate benefit for implant crowns has been made in accordance with your policy or plan benefit documents. Member is financially responsible for the difference in cost of the billed service and the alternate benefit.
H054	Alternate benefit applied for composite/resin fillings on primary posterior teeth. Member is responsible for the difference in the cost.
H061	Benefit has been applied to Patient's deductible for the year.
H062	The maximum lifetime benefit allowable by the plan for this type of service has been reached.
H066	Procedure has exceeded the maximum number allowed within a 12 month benefit period.
H070	Submitted procedure is not covered or does not meet the guidelines for benefit coverage.
H077	The Member cannot be identified in our system.
H080	The benefit for a tooth restoration includes pulpal protection.
H084	Sealants are covered on permanent, unfilled molars and bicuspids only.
H085	There is a waiting period for the procedure(s). No benefit is payable until the waiting period has been satisfied.
H090	No benefit is payable for this procedure when billed with similar procedures performed on the same day.
H099	Service dates are outside the Member's coverage dates.
H100	Missing/incomplete/invalid tooth number. Please resubmit claim with required information.
H101	Procedure code is not compatible with submitted tooth number. Please correct and resubmit claim.
H115	Missing/incomplete/invalid tooth surface information. Please correct and resubmit claim.
H118	This claim is a duplicate of a previously submitted and processed claim.
H119	This service is paid only once in a patient's lifetime.
H120	Patient is not eligible for the submitted service because of benefit age limitations.
H122	General Anesthesia in conjunction with the submitted service is only a covered benefit for children under the age of 8.
H135	Alternate benefit has been applied. Patient is responsible for the difference in cost between the alternate benefit and treatment performed.
H145	Procedure is only allowed one time per patient per dentist.
H146	Procedure has exceeded the maximum allowable occurrences in one day.
H147	Certain procedure(s) must be performed on the indicated tooth prior to this procedure.
H149	Certain procedure(s) may never have been performed on the indicated tooth prior to the service date of this procedure.
H151	Patient has an existing orthodontic claim.
H153	One of several procedures must be performed on the indicated tooth prior to or on the same date of service of the submitted procedure.
H159	Fluoride is covered through age 14, an alternate benefit has been applied. Member is responsible for the difference in cost.
H161	Procedure has exceeded the maximum number allowed within a 24 month benefit period.
H162	Procedure has exceeded the maximum number allowed within a 36 month benefit period.
H163	Procedure has exceeded the maximum number allowed within a 60 month benefit period.
H164	No benefit is payable for this procedure when billed with other procedures performed on the same day.
H167	This procedure is allowed one time per month.
H169	Services performed by a non-participating provider are not covered.
H171	The maximum yearly benefit allowed by the plan for this type of service has been reached.
H172	Our records indicate we are the secondary carrier for this patient. Please resubmit claim with the primary carrier's explanation of benefits.
H173	The timely filing limit allowed for submission of claims has expired.
H177	Patient is not listed as a covered dependent for the subscriber.
H179	This is a Silver Plan patient. Please refer to the patient's Silver Plan schedule of discounted fees. The Silver Plan is a discount plan; it is not an insurance product. No benefit is payable by the plan and coordination of benefits with insured plans does not apply.
H180	Member receives a 20% discount from the contracted provider's usual fee for this service. Patient is responsible for charges up to the discounted fee after the plan payment.
H181	Member is responsible for charges above the allowed amount.
H182	Charges above the PLAN ALLOWABLE are not payable by the plan. The member is responsible for the balance after the plan payment up to the APPROVED AMOUNT.
H183	No benefit is payable for the replacement of teeth that were missing/extracted prior to the effective date of coverage on this plan.
H185	Member receives a 20% discount from the provider's usual fees. This provider's billed fees reflect the 20% discount. The member is responsible for charges above the allowed amount up to the approved amount.
H186	Procedure was submitted without fees.
H998	Claim was processed and benefits determined with the incorrect patient. Claim and payment have been reversed from the incorrect patient. Claim will be re-processed with the correct patient.
OC1	Claim has been manually adjusted. See notes for details.