



Beta Health Association, Inc.
Dental Fee Schedule

Alpha Plan #A
Form 7109

ADA CODE	DENTAL PROCEDURE/ADA CODE DESCRIPTION	NORMAL FEE	ALPHA PLAN #A	YOU SAVE
<u>Diagnostic Services (Exams and X-rays)</u>				
999	ROUTINE OFFICE VISIT	\$ 35	\$ 5	86%
120	PERIODIC ORAL EVALUATION	\$ 53	No Cost	100%
140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	\$ 79	\$ 15	81%
150	COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT	\$ 97	\$ 12	87%
210	X-RAY INTRAORAL COMPLETE SERIES INC. BITEWINGS	\$ 134	\$ 31	77%
220	X-RAY INTRAORAL-PERAPICAL-FIRST FILM	\$ 31	\$ 6	79%
230	X-RAY INTRAORAL PERIAPICAL EACH ADDITIONAL FILM	\$ 26	\$ 5	80%
240	X-RAY INTRA ORAL-OCCLUSAL FILM	\$ 48	\$ 5	89%
250	X-RAY EXTRAORAL-FIRST FILM	\$ 75	\$ 5	94%
260	X-RAY EXTRAORAL-EACH ADDITIONAL FILM	\$ 63	\$ 5	92%
270	X-RAY BITEWING-SINGLE FILM	\$ 31	No Cost	100%
272	X-RAY BITEWING-2 FILMS	\$ 48	No Cost	100%
274	X-RAY BITEWING-4 FILMS	\$ 68	No Cost	100%
330	X-RAY PANORAMIC FILM	\$ 116	\$ 51	56%
340	CEPHALOMETRIC FILM	\$ 137	\$ 60	56%
460	PULP VITALITY TEST	\$ 61	No Cost	100%
470	DIAGNOSTIC CASTS	\$ 122	\$ 51	58%
999	EMERGENCY VISIT (SAME DAY)	\$ 90	\$ 25	72%
<u>Preventive Services (Cleanings)</u>				
1110	PROPHYLAXIS-ADULT CLEANING (EVERY 6 MONTHS)	\$ 96	\$ 18	81%
1120	PROPHYLAXIS-CHILD CLEANING (EVERY 6 MONTHS)	\$ 72	\$ 18	75%
1203	TOPICAL APPLICATION OF FLUORIDE NOT INCL/PROPHY-CHILD	\$ 39	\$ 11	71%
1330	ORAL HYGIENE INSTRUCTIONS	\$ 63	No Cost	100%
1351	SEALANT PER TOOTH	\$ 58	\$ 12	79%
1510	SPACE MAINTAINER FIXED UNILATERAL	\$ 338	\$ 183	46%
1515	SPACE MAINTAINER FIXED BILATERAL	\$ 461	\$ 261	43%
1520	SPACE MAINTAINER-REMOVABLE-UNILATERAL	\$ 418	\$ 213	49%
1525	SPACE MAINTAINER-REMOVABLE-BILATERAL	\$ 522	\$ 246	53%
1550	RE-CEMENTATION OF SPACE MAINTAINER	\$ 90	\$ 22	76%
1999	ADDITIONAL PROPHY (FOR PERIO MAINTENANCE)	\$ 96	\$ 41	57%
<u>Restorative Services (Fillings, Crowns, Inlays and Onlays)</u>				
2140	AMALGAM-1 SURFACE (PRIMARY OR PERMANENT)	\$ 150	\$ 40	73%
2150	AMALGAM-2 SURFACES (PRIMARY OR PERMANENT)	\$ 195	\$ 51	74%
2160	AMALGAM-3 SURFACES (PRIMARY OR PERMANENT)	\$ 232	\$ 61	74%
2161	AMALGAM-4 OR MORE SURFACES (PRIMARY OR PERMANENT)	\$ 272	\$ 70	74%
2330	RESIN BASED COMPOSITE 1 SURFACE (ANTERIOR)	\$ 169	\$ 53	69%
2331	RESIN BASED COMPOSITE 2 SURFACES (ANTERIOR)	\$ 212	\$ 64	70%
2332	RESIN BASED COMPOSITE 3 SURFACES (ANTERIOR)	\$ 264	\$ 83	68%
2335	RESIN 4 OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	\$ 328	\$ 124	62%
2390	RESIN BASED COMPOSITE CROWN (ANTERIOR)	\$ 476	\$ 262	45%
2391	RESIN BASED COMPOSITE ONE SURFACE (POSTERIOR)	\$ 188	\$ 105	44%
2392	RESIN BASED COMPOSITE TWO SURFACE (POSTERIOR)	\$ 243	\$ 146	40%
2393	RESIN BASED COMPOSITE THREE SURFACE (POSTERIOR)	\$ 305	\$ 185	39%
2394	RESIN BASED COMPOSITE FOUR OR MORE SURFACES (POSTERIOR)	\$ 364	\$ 200	45%
*2510	INLAY-METALLIC-ONE SURFACE	\$ 906	\$ 318	65%
*2520	INLAY-METALLIC-TWO SURFACE	\$ 936	\$ 328	65%
*2530	INLAY-METALLIC-THREE OR MORE SURFACES	\$ 991	\$ 347	65%
*2542	ONLAY-METALLIC-TWO SURFACES	\$ 1,005	\$ 352	65%
*2543	ONLAY-METALLIC-THREE SURFACES	\$ 1,037	\$ 364	65%
*2544	ONLAY-METALLIC-FOUR OR MORE SURFACES	\$ 1,069	\$ 374	65%
*2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	\$ 965	\$ 338	65%
*2650	INLAY-RESIN BASED COMPOSITE-ONE SURFACE	\$ 927	\$ 324	65%
*2651	INLAY-RESIN BASED COMPOSITE-TWO SURFACES	\$ 952	\$ 333	65%
*2652	INLAY-RESIN BASED COMPOSITE-THREE OR MORE SURFACES	\$ 993	\$ 347	65%
*2710	CROWN-RESIN BASED COMPOSITE (INDIRECT)	\$ 963	\$ 337	65%
*2720	CROWN-RESIN WITH HIGH NOBLE METAL	\$ 1,139	\$ 398	65%
*2721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	\$ 1,032	\$ 361	65%
*2722	CROWN RESIN WITH NOBLE METAL	\$ 1,048	\$ 377	64%
*2740	CROWN PORCELAIN/CERAMIC SUBSTRATE	\$ 1,196	\$ 419	65%
*2750	CROWN PORCELAIN FUSED TO HIGH NOBLE METAL	\$ 1,164	\$ 399	66%
*2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$ 1,054	\$ 330	69%
*2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	\$ 1,091	\$ 385	65%

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<u>Restorative Services (Fillings, Crowns, Inlays and Onlays) Con't</u>				
*2790	CROWN FULL CAST HIGH NOBLE METAL	\$ 1,154	\$ 381	67%
*2791	CROWN FULL CAST PREDOMINANTLY BASE METAL	\$ 1,028	\$ 333	68%
*2792	CROWN FULL CAST NOBLE METAL	\$ 1,058	\$ 359	66%
2910	RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION	\$ 116	\$ 19	83%
2920	RECEMENT CROWN	\$ 116	\$ 36	69%
2930	PREFAB. STAINLESS STEEL CROWN-PRIMARY	\$ 291	\$ 110	62%
2931	PREFAB STAINLESS STEEL CROWN-PERMANENT	\$ 355	\$ 140	60%
2932	PREFAB. RESIN CROWN	\$ 376	\$ 157	58%
2933	PREFAB. STAINLESS STEEL CROWN WITH RESIN WINDOW	\$ 398	\$ 179	55%
2940	SEDATIVE FILLING	\$ 132	\$ 42	68%
2950	CORE BUILDUP INCLUDING ANY PINS	\$ 292	\$ 91	69%
2951	PIN RETENTION PER TOOTH IN ADD. TO RESTORATION	\$ 81	\$ 29	64%
2952	CAST POST & CORE IN ADDITION TO CROWN	\$ 456	\$ 144	68%
2954	PREFAB POST & CORE IN ADDITION TO CROWN	\$ 365	\$ 112	69%
2955	POST REMOVAL (NOT IN CONJUNCTION WITH ENDODONTIC THERAPY)	\$ 317	\$ 139	56%
2960	LABIAL VENEER RESIN LAMINATE (CHAIRSIDE)	\$ 714	\$ 187	74%
2999	BLEACHING (PER ARCH)	\$ 270	\$ 162	40%
2999	\$125 ADDTL.CHARGE P/UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION			

*These co-payments do not include an allowable \$151 lab fee (per unit). Doctors, please make sure that all members understand what their fees will be and what the savings are from your Usual and Customary fees. Temporary crowns are included with permanent crown preparation.

<u>Endodontic Services (Root Canals)</u>				
3110	PULP CAP DIRECT EXCLUDING FINAL RESTORATION	\$ 90	\$ 30	66%
3120	PULP CAP INDIRECT EXCLUDING FINAL RESTORATION	\$ 93	\$ 33	65%
3220	THERAPEUTIC PULPOTOMY EXCLUDING FINAL RESTORATION	\$ 218	\$ 78	64%
3230	PULPAL THERAPY ANTERIOR, PRIMARY TOOTH EXCLUDING REST.	\$ 328	\$ 102	69%
3240	PULPAL THERAPY POSTERIOR, PRIMARY TOOTH EXCLUDING REST	\$ 370	\$ 113	70%
3310	ROOT CANAL THERAPY 1 CANAL (EXCLUDING FINAL RESTORATION)	\$ 778	\$ 292	62%
3320	ROOT CANAL THERAPY 2 CANALS (EXCLUDING FINAL RESTORATION)	\$ 874	\$ 336	62%
3330	ROOT CANAL THERAPY 3 CANALS OR MORE	\$ 1,058	\$ 416	61%
3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR	\$ 741	\$ 328	56%
3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID (FIRST ROOT)	\$ 805	\$ 366	55%
3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR (FIRST ROOT)	\$ 950	\$ 424	55%
3426	APICOECTOMY/PERIRADICULAR SURGERY-EACH ADDITIONAL ROOT	\$ 450	\$ 161	64%
3430	RETROGRADE FILLING-PER ROOT	\$ 315	\$ 116	63%
3910	SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM	\$ 279	\$ 64	77%
<u>Periodontic Services (Gum Disease)</u>				
4210	GINGIVOPLASTY OR GINGIVECTOMY-4+ CONTIGUOUS OR BOUNDED SP. TEETH P/QUAD	\$ 704	\$ 344	51%
4211	GINGIVECTOMY OR GINGIVOPLASTY-1 TO 3 CONTIGUOUS OR BOUNDED SP. TEETH P/QUAD	\$ 323	\$ 189	41%
4240	GINGIVAL FLAP PROCEDURE, INCL.ROOT PLNG -4+ CONTIG. OR BOUNDED SP. TEETH P/QUAD	\$ 820	\$ 352	57%
4260	OSSEOUS SURG. INCL. FLAP ENTRY & CLOSURE-4+ CONTIG. OR BOUNDED SP. TEETH P/QUAD	\$ 1,138	\$ 538	53%
4320	PROVISIONAL SPLINTING-INTRACORNIAL	\$ 556	\$ 269	52%
4321	PROVISIONAL SPLINTING-EXTRACORNIAL	\$ 527	\$ 264	50%
4341	PERIODONTAL SCALING & ROOT PLNG- 4+ TEETH PER QUAD	\$ 265	\$ 131	51%
4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMP.EVAL. & DIAGNOSIS	\$ 197	\$ 96	51%
4910	PERIODONTAL MAINTENANCE	\$ 146	\$ 60	59%
4999	PERIO SCREENING AND SCORING	\$ 30	\$ 15	50%
<u>Prosthodontics (Removable/Complete Dentures, etc.)</u>				
5110	COMPLETE DENTURE-MAXILLARY	\$ 1,799	\$ 563	69%
5120	COMPLETE DENTURE-MANDIBULAR	\$ 1,799	\$ 563	69%
5130	IMMEDIATE DENTURE-MAXILLARY	\$ 1,921	\$ 764	60%
5140	IMMEDIATE DENTURE-MANDIBULAR	\$ 1,958	\$ 778	60%
5211	MAXILLARY PART. DENTURE-RESIN BASE (INCL. CLASPS & TEETH)	\$ 1,474	\$ 472	68%
5212	MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCL. CLASPS & TEETH)	\$ 1,448	\$ 451	69%
5213	MAXILLARY PART. DENT.-CST MTL FRMEWRK W/RESIN DENT. BASE (INCL/CLASPS & TEETH)	\$ 1,885	\$ 560	70%
5214	MANDIBULAR PART. DENT.-CST MTL FRMEWRK W/RESIN DENT. BASE (INCL/CLASPS & TEETH)	\$ 1,889	\$ 558	70%
5410	ADJUST COMPLETE DENTURE-MAXILLARY	\$ 96	\$ 36	63%
5411	ADJUST COMPLETE DENTURE-MANDIBULAR	\$ 95	\$ 36	63%
5421	ADJUST PARTIAL DENTURE-MAXILLARY	\$ 95	\$ 36	63%
5422	ADJUST PARTIAL DENTURE-MANDIBULAR	\$ 95	\$ 36	63%
5510	REPAIR BROKEN COMPLETE DENTURE BASE	\$ 231	\$ 88	62%
5520	REPLACE MISSING OF BROKEN TEETH-COMP.DENTURE-EACH TOOTH	\$ 197	\$ 62	68%
5610	REPAIR RESIN DENTURE BASE	\$ 225	\$ 82	63%
5620	REPAIR CAST FRAMEWORK	\$ 313	\$ 139	56%
5630	REPAIR OR REPLACE BROKEN CLASP	\$ 286	\$ 105	63%
5640	REPLACE BROKEN TEETH-PER TOOTH	\$ 198	\$ 68	66%
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	\$ 241	\$ 93	62%
5660	ADD CLASP TO EXISTING PARTIAL DENTURE	\$ 292	\$ 121	59%

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<u>Prostodontics (Removable/ Complete Dentures, etc.) Con't</u>				
5710	REBASE COMPLETE MAXILLARY DENTURE	\$ 630	\$ 276	56%
5711	REBASE COMPLETE MANDIBULAR DENTURE	\$ 629	\$ 276	56%
5720	REBASE MAXILLARY PARTIAL DENTURE	\$ 609	\$ 241	60%
5721	REBASE MANDIBULAR PARTIAL DENTURE	\$ 609	\$ 242	60%
5730	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	\$ 402	\$ 175	56%
5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	\$ 402	\$ 175	56%
5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	\$ 397	\$ 167	58%
5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	\$ 402	\$ 167	58%
5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	\$ 503	\$ 172	66%
5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	\$ 503	\$ 172	66%
5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	\$ 503	\$ 162	68%
5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	\$ 503	\$ 161	68%
5850	TISSUE CONDITIONING MAXILLARY	\$ 231	\$ 73	68%
5851	TISSUE CONDITIONING MANDIBULAR	\$ 233	\$ 72	69%

NOTE: In addition to the fees listed above in section 5000 thru 6000, additional fees may be charged for upgraded teeth and enhanced cosmetics, personalization beyond norm or techniques involving precision dentures.

<u>Prostodontics (fixed/PartialDentures, etc.)</u>				
*6210	PONTIC-CAST HIGH NOBLE METAL	\$ 1,133	\$ 374	67%
*6211	PONTIC-CAST PREDOMINANTLY BASE METAL	\$ 1,037	\$ 324	69%
*6212	PONTIC-CAST NOBLE METAL	\$ 1,075	\$ 358	67%
*6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	\$ 1,161	\$ 398	66%
*6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$ 1,058	\$ 363	66%
*6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	\$ 1,084	\$ 376	65%
*6250	PONTIC-RESIN WITH HIGH NOBLE METAL	\$ 1,085	\$ 366	66%
*6251	PONTIC-RESIN WITH PREDOMINANTLY BASE METAL	\$ 1,042	\$ 354	66%
*6252	PONTIC-RESIN WITH NOBLE METAL	\$ 1,044	\$ 354	66%
*6720	CROWN-RESIN WITH HIGH NOBLE METAL	\$ 1,154	\$ 404	65%
*6721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	\$ 1,042	\$ 364	65%
*6722	CROWN-RESIN WITH NOBLE METAL	\$ 1,067	\$ 384	64%
*6750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	\$ 1,164	\$ 399	66%
*6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$ 1,052	\$ 367	65%
*6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	\$ 1,079	\$ 380	65%
*6790	CROWN-FULL CAST HIGH NOBLE METAL	\$ 1,133	\$ 374	67%
*6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	\$ 1,042	\$ 345	67%
*6792	CROWN-FULL CAST NOBLE METAL	\$ 1,084	\$ 368	66%
6930	RECEMENT FIXED PARTIAL DENTURE	\$ 185	\$ 69	63%

These co-payments do not include an allowable \$151 lab fee (per unit). Doctors, please make sure that all members understand what their fees will be and what the savings are from your Usual and Customary fee.

<u>Oral Surgery (Extractions, etc.)</u>				
7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	\$ 185	\$ 51	72%
7210	SURGICAL EXT. ERUPTED TOOTH WITH REMOVAL OF BONE	\$ 295	\$ 87	71%
7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	\$ 345	\$ 98	71%
7230	REMOVAL OF IMPACTED TOOTH PARTIALLY BONY	\$ 419	\$ 169	60%
7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	\$ 524	\$ 212	60%
7241	REMOVAL OF IMPACTED TOOTH-COMpletely BONY W/ UNUSUAL SURG. COMPLICATION	\$ 635	\$ 259	59%
7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	\$ 322	\$ 124	61%
7270	TOOTH REIMPL. AND/OR STAB. OF ACC.EVULSED OR DISPL. TOOTH	\$ 609	\$ 243	60%
7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	\$ 540	\$ 235	56%
7285	BIOPSY OF ORAL TISSUE-HARD (BONE-TOOTH)	\$ 497	\$ 217	56%
7286	BIOPSY OF ORAL TISSUE-SOFT	\$ 344	\$ 150	56%
7310	ALVEOPLASTY IN CONJ. WITH EXT.- PER QUAD	\$ 329	\$ 132	60%
7320	ALVEOPLASTY NOT IN CONJ WITH EXT- PER QUAD	\$ 528	\$ 205	61%
7510	INCISION AND DRAINAGE ABSCESS- INTRAORAL SOFT TISSUE	\$ 255	\$ 99	61%
7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5CM	\$ 341	No Cost	100%
7960	FRENULECTOMY (FRENECTOMY OR FRENOTOMY)- SEPARATE PROCEDURE	\$ 498	\$ 138	72%
7970	EXCISION OF HYPERPLASTIC TISSUE- PER ARCH	\$ 582	\$ 213	63%

<u>General Miscellaneous Services</u>				
9110	EMERGENCY PALATIVE TREATMENT OF DENTAL PAIN- MINOR PROCEDURE	\$ 138	\$ 51	63%
9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE - FIRST 30 MINUTES	\$ 95	\$ 27	72%
9310	CONSULTATION (DIAG. SERV. PROV. BY DENTIST OR PHYSICIAN OTHER THAN PRACTITIONER PROV. TREATMNT)	\$ 159	No Cost	100%
9910	APPLICATION OF DESENSITIZING MEDICAMENT	\$ 73	\$ 6	92%
9941	FABRICATION OF ATHLETIC MOUTHGUARD	\$ 315	\$ 107	66%
9951	OCCLUSAL ADJUSTMENT-LIMITED	\$ 212	\$ 77	64%
9952	OCCLUSAL ADJUSTMENT-COMplete	\$ 770	\$ 286	63%
9999	MISSED APPOINTMENT (WITHOUT 24 HOUR NOTICE)	\$ 54	\$ 30	44%

Current Dental Terminology©American Dental Association

ADA CODE	DENTAL PROCEDURE/ADA CODE DESCRIPTION	NORMAL FEE	ALPHA PLAN #A	YOU SAVE
<u>Orthodontics (Braces) for Children & Adults</u>				
	<u>Monthly Payment</u>			
	13 MONTH TREATMENT PLAN	(\$137/MONTH)	\$ 3,114	\$ 2,409 23%
	16 MONTH TREATMENT PLAN	(\$137/MONTH)	\$ 3,625	\$ 2,820 22%
	19 MONTH TREATMENT PLAN	(\$137/MONTH)	\$ 4,135	\$ 3,231 22%
	22 MONTH TREATMENT PLAN	(\$137/MONTH)	\$ 4,606	\$ 3,642 21%
	25 MONTH TREATMENT PLAN	(\$137/MONTH)	\$ 5,158	\$ 4,053 21%
	28 MONTH TREATMENT PLAN	(\$137/MONTH)	\$ 5,669	\$ 4,464 21%
	31 MONTH TREATMENT PLAN	(\$137/MONTH)	\$ 6,179	\$ 4,875 21%
	34 MONTH TREATMENT PLAN	(\$137/MONTH)	\$ 6,690	\$ 5,286 21%
	36 MONTH TREATMENT PLAN	(\$137/MONTH)	\$ 6,951	\$ 5,560 20%

Other Orthodontic Guidelines

1. A \$382 charge will apply at the end of treatment (included in the above amounts) to cover all retention office visits (unlimited).
2. Services not listed above will be discounted 30% off of the participating Orthodontist's Usual and Customary fees (except #5 listed below).
3. Services must only be provided by a contracted Orthodontic Specialist.
4. The amounts listed above also include an initial one-time \$246 charge for all records, mold, x-rays, etc. to determine the Orthodontic Treatment for the patient.
5. Invisalign® procedures are to be discounted 15% off the participating Orthodontist's Usual and Customary fees.

All Plans General Limitations and Exclusions

1. All fees listed above do not include all appropriate lab fees. Member must agree (in writing) to all upgraded materials before treatment is started. See each section for specific details (if applicable).
2. All patients are responsible for paying all fees (as listed above) at the time services are rendered.
3. These fees are for General Dentists only. A participating specialist list is available by calling our office at 303-744-3007 or 1-800-807-0706.
4. Any procedures not listed will be discounted 20% off the participating General Dentists normal fees.
5. Medical costs associated with any dental procedures are not covered.
6. Dentures or appliances will be replaced only after 3 years have elapsed since such dentures or appliances were provided under any plan program, unless the denture or appliance becomes unserviceable due to illness or other causes not controlled by other means. Replacement of dentures, appliances, or bridgework due to loss or theft are not covered.
7. Any dental treatment started prior to the Member's eligibility to receive services under this plan or started after a Member's termination are not covered.
8. Failure to follow the prescribed treatment or accidents occurring during the course of treatment may result in additional charges by your plan provider.
9. Failure to pay scheduled fees at the time service is rendered may prevent future dental services from being received until all fees have been paid in full.
10. Services provided by non-participating dentists are not covered.
11. Services which, in the opinion of the attending dentist, are not necessary for the patient's dental health, or are contrary to established dental ethics are not covered.
12. Cosmetic dental procedures are covered only if the attending dentist and patient agree on the specific procedure.
13. Services which are compensable under Worker's Compensation or employer liability laws are not covered.
14. General anesthesia and IV sedation are not covered.
15. Myofunctional therapy procedure for training, treating or developing muscles in and around the jaw or mouth including TMJ are not covered except by participating plan specialists.
16. Any dental procedure or service that cannot be performed in the dental office due to general and/or physical limitations of a member are not covered.
17. Expenses incurred for dental procedures initiated prior to member's eligibility or after termination are not covered.
18. Any services that the Participating General Dentist recommends be performed by a specialist are covered only by a plan participating specialist.
19. The liability of Beta Health Association, Inc. is limited to the return of the membership fees paid for one year by the member.
20. Extractions for asymptomatic third molars (wisdom teeth) are not covered unless causing movement of the teeth. An example of symptomatic include severe decay, and ontogenic cysts, chronic pericoronitis, and infection.
21. The Beta Health Association, Inc. dental programs do not constitute dental insurance and are considered discount, fee-for-service dental plans.
22. Fees are subject to change on an as needed basis. Please contact Beta Health Association, Inc. for current fees.