



Dental Plan Options Effective January 1, 2016

	Required Plans		Optional Plans	
	 BEHA HEALTH ASSOCIATION, INC. <small>*Dental Plan Specialists Since 1990*</small>			
PLAN SELECTION NAME	Plan 1-Alpha	Plan 2-CarePOS	Plan 3-Delta Plan A Low	Plan 4-Delta Plan B High
NETWORK SPECIFICS	See Network Dentist Only		See Any Dentist	
Colorado Network	Approximately 850 combined		1248 PPO and 2557 Premier (combines both networks)	
National Network	Approximately 100,000		Approximately 140,000	
DEDUCTIBLE (calendar year)	No deductibles to satisfy		\$25 / \$75	\$25 / \$75
Deductible waived for preventive care?	No deductibles to satisfy		Yes	
BENEFIT MAXIMUM	Unlimited (use as much as you like)		\$1,000 per person	\$1,500 per person
PREVENTIVE CARE (cleanings, exams, x rays, fluoride, sealants, space maintainers)	Save up to 100% fee schedule) (see	Save up to 80% fee schedule) (see	100%	100%
Do cleanings, exams and xrays apply to plan maximum?	No. There are no plan maximums.		No	
BASIC SERVICES (fillings, simple extractions)	Save up to 80% fee schedule) (see	Save up to 70% fee schedule) (see	80%	100%
MAJOR SERVICES (surgical extractions, endodontics, periodontics, crowns, bridges, dentures, implants)	Save up to 60% fee schedule) (see	Save up to 50% fee schedule) (see	50%	50%
Adult Implants covered?	Yes		Yes, restorative phase only	Yes, restorative phase only
ORTHODONTICS	Yes		No	Yes
Available for Children and Adults?	Yes		No	Yes
Savings and/or benefit level	Save up to 23% off of the normal full fee	Save up to 20% off of the normal full fee	Not Covered	No deductible, 50% to a \$1000 Lifetime Maximum
WAITING PERIODS	No waiting periods on any procedures		12-Month Waiting Period for Major & Ortho if not currently enrolled or if a new hire during the year	



**Beta Health Association, Inc.
Dental Fee Schedule**

Plans #1 and #2

Form 9110

ADA CODE	DENTAL PROCEDURE/ADA CODE DESCRIPTION	NORMAL FEE	ALPHA PLAN #19	CarePOS PLAN
<u>Diagnostic Services (Exams and X-rays)</u>				
999	ROUTINE OFFICE VISIT	\$ 35	\$ 5	20% discount
120	PERIODIC ORAL EVALUATION	\$ 53	NO COST	\$ 25
140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	\$ 79	\$ 15	\$ 42
150	COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT	\$ 97	\$ 12	\$ 43
210	X-RAY INTRAORAL COMPLETE SERIES INC. BITEWINGS	\$ 134	\$ 29	\$ 75
220	X-RAY INTRAORAL PERIAPICAL-FIRST FILM	\$ 31	\$ 6	\$ 14
230	X-RAY INTRAORAL PERIAPICAL EACH ADDITIONAL FILM	\$ 26	\$ 5	\$ 12
240	X-RAY INTRAORAL OCCLUSAL FILM	\$ 48	\$ 5	\$ 21
250	X-RAY EXTRAORAL FIRST FILM	\$ 75	\$ 5	\$ 29
260	X-RAY EXTRAORAL-EACH ADDITIONAL FILM	\$ 63	\$ 5	\$ 28
270	X-RAY BITEWING-SINGLE FILM	\$ 31	NO COST	\$ 15
272	X-RAY BITEWING-2 FILMS	\$ 48	NO COST	\$ 23
274	X-RAY BITEWING-4 FILMS	\$ 68	NO COST	\$ 33
330	X-RAY PANORAMIC FILM	\$ 116	\$ 49	\$ 61
340	CEPHALOMETRIC FILM	\$ 137	\$ 60	\$ 75
460	PULP VITALITY TEST	\$ 61	NO COST	\$ 30
470	DIAGNOSTIC CASTS	\$ 122	\$ 49	\$ 64
999	EMERGENCY VISIT (SAME DAY)	\$ 90	\$ 25	20% discount
<u>Preventive Services (Cleanings)</u>				
1110	PROPHYLAXIS-ADULT CLEANING (EVERY 6 MONTHS)	\$ 96	\$ 15	\$ 50
1120	PROPHYLAXIS-CHILD CLEANING (EVERY 6 MONTHS)	\$ 72	\$ 15	\$ 36
1203	TOPICAL APPLICATION OF FLUORIDE NOT INCL/PROPHY-CHILD	\$ 39	\$ 11	\$ 21
1330	ORAL HYGIENE INSTRUCTIONS	\$ 63	NO COST	\$ 37
1351	SEALANT PER TOOTH	\$ 58	\$ 12	\$ 28
1510	SPACE MAINTAINER FIXED UNILATERAL	\$ 338	\$ 173	\$ 179
1515	SPACE MAINTAINER FIXED BILATERAL	\$ 461	\$ 250	\$ 235
1520	SPACE MAINTAINER-REMOVABLE-UNILATERAL	\$ 418	\$ 213	\$ 222
1525	SPACE MAINTAINER-REMOVABLE-BILATERAL	\$ 522	\$ 246	\$ 304
1550	RE-CEMENTATION OF SPACE MAINTAINER	\$ 90	\$ 17	\$ 38
1999	ADDITIONAL PROPHY (FOR PERIO MAINTENANCE)	\$ 96	\$ 41	20% discount
<u>Restorative Services (Fillings, Crowns, Inlays and Onlays)</u>				
2140	AMALGAM-1 SURFACE (PRIMARY OR PERMANENT)	\$ 150	\$ 33	\$ 66
2150	AMALGAM-2 SURFACES (PRIMARY OR PERMANENT)	\$ 195	\$ 44	\$ 86
2160	AMALGAM-3 SURFACES (PRIMARY OR PERMANENT)	\$ 232	\$ 54	\$ 103
2161	AMALGAM-4 OR MORE SURFACES (PRIMARY OR PERMANENT)	\$ 272	\$ 63	\$ 126
2330	RESIN BASED COMPOSITE 1 SURFACE (ANTERIOR)	\$ 169	\$ 45	\$ 77
2331	RESIN BASED COMPOSITE 2 SURFACES (ANTERIOR)	\$ 212	\$ 58	\$ 99
2332	RESIN BASED COMPOSITE 3 SURFACES (ANTERIOR)	\$ 264	\$ 77	\$ 122
2335	RESIN 4 OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	\$ 328	\$ 124	\$ 142
2390	RESIN BASED COMPOSITE CROWN (ANTERIOR)	\$ 476	\$ 262	\$ 203
2391	RESIN BASED COMPOSITE ONE SURFACE (POSTERIOR)	\$ 188	\$ 98	\$ 87
2392	RESIN BASED COMPOSITE TWO SURFACE (POSTERIOR)	\$ 243	\$ 135	\$ 121
2393	RESIN BASED COMPOSITE THREE SURFACE (POSTERIOR)	\$ 305	\$ 172	\$ 150
2394	RESIN BASED COMPOSITE FOUR OR MORE SURFACES (POSTERIOR)	\$ 364	\$ 188	\$ 156
*2510	INLAY-METALLIC-ONE SURFACE	\$ 906	\$ 299	\$ 366
*2520	INLAY-METALLIC-TWO SURFACE	\$ 936	\$ 309	\$ 415
*2530	INLAY-METALLIC-THREE OR MORE SURFACES	\$ 991	\$ 327	\$ 478
*2542	ONLAY-METALLIC-TWO SURFACES	\$ 1,005	\$ 332	\$ 439
*2543	ONLAY-METALLIC-THREE SURFACES	\$ 1,037	\$ 343	\$ 491
*2544	ONLAY-METALLIC-FOUR OR MORE SURFACES	\$ 1,069	\$ 352	\$ 512
*2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	\$ 965	\$ 318	\$ 431
*2650	INLAY-RESIN BASED COMPOSITE-ONE SURFACE	\$ 927	\$ 306	\$ 284
*2651	INLAY-RESIN BASED COMPOSITE-TWO SURFACES	\$ 952	\$ 314	\$ 337
*2652	INLAY-RESIN BASED COMPOSITE-THREE OR MORE SURFACES	\$ 993	\$ 328	\$ 355
*2710	CROWN-RESIN BASED COMPOSITE (INDIRECT)	\$ 963	\$ 319	\$ 227
*2720	CROWN-RESIN WITH HIGH NOBLE METAL	\$ 1,139	\$ 375	\$ 625
*2721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	\$ 1,032	\$ 340	\$ 584
*2722	CROWN RESIN WITH NOBLE METAL	\$ 1,048	\$ 346	\$ 597
*2740	CROWN PORCELAIN/CERAMIC SUBSTRATE	\$ 1,196	\$ 395	\$ 639
*2750	CROWN PORCELAIN FUSED TO HIGH NOBLE METAL	\$ 1,164	\$ 384	\$ 631
*2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$ 1,054	\$ 315	\$ 589
*2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	\$ 1,091	\$ 370	\$ 602

ADA CODE	DENTAL PROCEDURE/ADA CODE DESCRIPTION	NORMAL FEE	ALPHA PLAN #19	CarePOS PLAN
<u>Restorative Services (Fillings, Crowns, Inlays and Onlays) Con't</u>				
*2790	CROWN FULL CAST HIGH NOBLE METAL	\$ 1,154	\$ 366	\$ 608
*2791	CROWN FULL CAST PREDOMINANTLY BASE METAL	\$ 1,028	\$ 318	\$ 580
*2792	CROWN FULL CAST NOBLE METAL	\$ 1,058	\$ 345	\$ 590
2910	RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION	\$ 116	\$ 15	\$ 52
2920	RECEMENT CROWN	\$ 116	\$ 31	\$ 54
2930	PREFAB. STAINLESS STEEL CROWN-PRIMARY	\$ 291	\$ 101	\$ 149
2931	PREFAB STAINLESS STEEL CROWN-PERMANENT	\$ 355	\$ 123	\$ 167
2932	PREFAB. RESIN CROWN	\$ 376	\$ 157	\$ 184
2933	PREFAB. STAINLESS STEEL CROWN WITH RESIN WINDOW	\$ 398	\$ 179	\$ 205
2940	SEDATIVE FILLING	\$ 132	\$ 37	\$ 57
2950	CORE BUILDUP INCLUDING ANY PINS	\$ 292	\$ 82	\$ 141
2951	PIN RETENTION PER TOOTH IN ADD. TO RESTORATION	\$ 81	\$ 23	\$ 29
2952	POST & CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	\$ 456	\$ 134	\$ 216
2954	PREFAB POST & CORE IN ADDITION TO CROWN	\$ 365	\$ 107	\$ 179
2955	POST REMOVAL (NOT IN CONJUNCTION WITH ENDODONTIC THERAPY)	\$ 317	\$ 139	\$ 135
2960	LABIAL VENEER RESIN LAMINATE (CHAIRSIDE)	\$ 714	\$ 187	\$ 440
2999	BLEACHING (PER ARCH)	\$ 270	\$ 162	20% discount
2999	\$125 ADDTL.CHARGE P/UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION			

*This applies to the Alpha Dental Plan only: 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	\$ 26	\$ 38
3120	PULP CAP INDIRECT EXCLUDING FINAL RESTORATION	\$ 93	\$ 27	\$ 30
3220	THERAPEUTIC PULPOTOMY EXCLUDING FINAL RESTORATION	\$ 218	\$ 72	\$ 92
3230	PULPAL THERAPY ANTERIOR, PRIMARY TOOTH EXCLUDING FINAL RESTORATION	\$ 328	\$ 102	\$ 97
3240	PULPAL THERAPY POSTERIOR, PRIMARY TOOTH EXCLUDING FINAL RESTORATION	\$ 370	\$ 113	\$ 104
3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	\$ 778	\$ 275	\$ 388
3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)	\$ 874	\$ 320	\$ 474
3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)	\$ 1,058	\$ 400	\$ 612
3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR	\$ 741	\$ 328	\$ 443
3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID (FIRST ROOT)	\$ 805	\$ 366	\$ 484
3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR (FIRST ROOT)	\$ 950	\$ 424	\$ 547
3426	APICOECTOMY/PERIRADICULAR SURGERY-EACH ADDITIONAL ROOT	\$ 450	\$ 161	\$ 182
3430	RETROGRADE FILLING-PER ROOT	\$ 315	\$ 116	\$ 134
3910	SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM	\$ 279	\$ 64	\$ 71
<u>Periodontic Services (Gum Disease)</u>				
4210	GINGIVOPLASY OR GINGIVECTOMY-4+ CONTIGUOUS OR BOUNDED SP. TEETH P/QUAD	\$ 704	\$ 333	\$ 379
4211	GINGIVECTOMY OR GINGIVOPLASTY-1 TO 3 CONTIGUOUS OR BOUNDED SP. TEETH P/QUAD	\$ 323	\$ 178	\$ 126
4240	GINGIVAL FLAP PROCEDURE, INCL.ROOT PLNG -4+ CONTIG. OR BOUNDED SP. TEETH P/QUAD	\$ 820	\$ 352	\$ 446
4260	OSSEOUS SURG. INCL. FLAP ENTRY & CLOSURE-4+ CONTIG. OR BOUNDED SP. TEETH P/QUAD	\$ 1,138	\$ 521	\$ 720
4320	PROVISIONAL SPLINTING-INTRACORONAL	\$ 556	\$ 260	\$ 240
4321	PROVISIONAL SPLINTING-EXTRACORONAL	\$ 527	\$ 246	\$ 211
4341	PERIODONTAL SCALING & ROOT PLNG- 4+ TEETH PER QUAD	\$ 265	\$ 112	\$ 130
4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMP.EVAL. & DIAGNOSIS	\$ 197	\$ 89	\$ 86
4910	PERIODONTAL MAINTENANCE	\$ 146	\$ 57	\$ 78
4999	PERIO SCREENING AND SCORING	\$ 30	\$ 10	20% discount
<u>Prostodontics (Removable/Complete Dentures, etc.)</u>				
5110	COMPLETE DENTURE-MAXILLARY	\$ 1,799	\$ 533	\$ 838
5120	COMPLETE DENTURE-MANDIBULAR	\$ 1,799	\$ 533	\$ 838
5130	IMMEDIATE DENTURE-MAXILLARY	\$ 1,921	\$ 764	\$ 915
5140	IMMEDIATE DENTURE-MANDIBULAR	\$ 1,958	\$ 778	\$ 915
5211	MAXILLARY PART. DENTURE-RESIN BASE (INCL. CLASPS, RESTS & TEETH)	\$ 1,474	\$ 463	\$ 823
5212	MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCL. CLASPS, RESTS & TEETH)	\$ 1,448	\$ 442	\$ 823
5213	MAXILLARY PART. DENT.-CST MTL FRMEWRK W/RESIN DENT. BASE (INCL/CLASPS, RESTS & TEETH)	\$ 1,885	\$ 547	\$ 926
5214	MANDIBULAR PART. DENT.-CST MTL FRMEWRK W/RESIN DENT. BASE (INCL/CLASPS, RESTS & TEETH)	\$ 1,889	\$ 545	\$ 926
5410	ADJUST COMPLETE DENTURE-MAXILLARY	\$ 96	\$ 36	\$ 46
5411	ADJUST COMPLETE DENTURE-MANDIBULAR	\$ 95	\$ 36	\$ 46
5421	ADJUST PARTIAL DENTURE-MAXILLARY	\$ 95	\$ 36	\$ 46
5422	ADJUST PARTIAL DENTURE-MANDIBULAR	\$ 95	\$ 36	\$ 46
5510	REPAIR BROKEN COMPLETE DENTURE BASE	\$ 231	\$ 88	\$ 91
5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE-EACH TOOTH	\$ 197	\$ 62	\$ 77
5610	REPAIR RESIN DENTURE BASE	\$ 225	\$ 82	\$ 100
5620	REPAIR CAST FRAMEWORK	\$ 313	\$ 139	\$ 107
5630	REPAIR OR REPLACE BROKEN CLASP	\$ 286	\$ 105	\$ 130
5640	REPLACE BROKEN TEETH-PER TOOTH	\$ 198	\$ 68	\$ 84
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	\$ 241	\$ 93	\$ 114
5660	ADD CLASP TO EXISTING PARTIAL DENTURE	\$ 292	\$ 121	\$ 138

ADA CODE	DENTAL PROCEDURE/ADA CODE DESCRIPTION	NORMAL FEE	ALPHA PLAN #19	CarePOS PLAN
<u>Prosthodontics (Removable/ Complete Dentures, etc.) Con't</u>				
5710	REBASE COMPLETE MAXILLARY DENTURE	\$ 630	\$ 276	\$ 340
5711	REBASE COMPLETE MANDIBULAR DENTURE	\$ 629	\$ 276	\$ 326
5720	REBASE MAXILLARY PARTIAL DENTURE	\$ 609	\$ 230	\$ 321
5721	REBASE MANDIBULAR PARTIAL DENTURE	\$ 609	\$ 231	\$ 321
5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	\$ 402	\$ 175	\$ 192
5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	\$ 402	\$ 175	\$ 192
5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	\$ 397	\$ 167	\$ 176
5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	\$ 402	\$ 167	\$ 176
5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	\$ 503	\$ 155	\$ 256
5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	\$ 503	\$ 155	\$ 256
5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	\$ 503	\$ 158	\$ 253
5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	\$ 503	\$ 157	\$ 253
5850	TISSUE CONDITIONING MAXILLARY	\$ 231	\$ 66	\$ 80
5851	TISSUE CONDITIONING MANDIBULAR	\$ 233	\$ 65	\$ 80

NOTE: For the Alpha Dental Plan only, 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>Prosthodontics (fixed/Partial Dentures, etc.)</u>				
*6210	PONTIC-CAST HIGH NOBLE METAL	\$ 1,133	\$ 359	\$ 553
*6211	PONTIC-CAST PREDOMINANTLY BASE METAL	\$ 1,037	\$ 303	\$ 517
*6212	PONTIC-CAST NOBLE METAL	\$ 1,075	\$ 320	\$ 538
*6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	\$ 1,161	\$ 383	\$ 545
*6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$ 1,058	\$ 312	\$ 504
*6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	\$ 1,084	\$ 331	\$ 531
*6250	PONTIC-RESIN WITH HIGH NOBLE METAL	\$ 1,085	\$ 345	\$ 538
*6251	PONTIC-RESIN WITH PREDOMINANTLY BASE METAL	\$ 1,042	\$ 323	\$ 497
*6252	PONTIC-RESIN WITH NOBLE METAL	\$ 1,044	\$ 325	\$ 512
*6720	CROWN-RESIN WITH HIGH NOBLE METAL	\$ 1,154	\$ 380	\$ 607
*6721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	\$ 1,042	\$ 344	\$ 577
*6722	CROWN-RESIN WITH NOBLE METAL	\$ 1,067	\$ 352	\$ 586
*6750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	\$ 1,164	\$ 384	\$ 622
*6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$ 1,052	\$ 315	\$ 581
*6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	\$ 1,079	\$ 335	\$ 594
*6790	CROWN-FULL CAST HIGH NOBLE METAL	\$ 1,133	\$ 359	\$ 602
*6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	\$ 1,042	\$ 323	\$ 569
*6792	CROWN-FULL CAST NOBLE METAL	\$ 1,084	\$ 330	\$ 591
6930	RECEMENT FIXED PARTIAL DENTURE	\$ 185	\$ 69	\$ 72

*This applies to the Alpha Dental Plan only: 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	\$ 46	\$ 85
7210	SURGICAL REMOVAL ERUPTED TOOTH WITH REMOVAL OF BONE AND/OR SECTION OF TOOTH	\$ 295	\$ 81	\$ 150
7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	\$ 345	\$ 92	\$ 169
7230	REMOVAL OF IMPACTED TOOTH PARTIALLY BONY	\$ 419	\$ 163	\$ 226
7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	\$ 524	\$ 210	\$ 265
7241	REMOVAL OF IMPACTED TOOTH-COMpletely BONY W/ UNUSUAL SURG. COMPLICATION	\$ 635	\$ 248	\$ 332
7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	\$ 322	\$ 118	\$ 143
7270	TOOTH REIMPL. AND/OR STAB. OF ACC.EVULSED OR DISPL. TOOTH	\$ 609	\$ 243	\$ 290
7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	\$ 540	\$ 235	\$ 318
7285	BIOPSY OF ORAL TISSUE-HARD (BONE-TOOTH)	\$ 497	\$ 217	\$ 517
7286	BIOPSY OF ORAL TISSUE-SOFT	\$ 344	\$ 150	\$ 230
7310	ALVEOPLASTY IN CONJ. WITH EXT.4 OR MORE TEETH OR TOOTH SPACES PER QUAD	\$ 329	\$ 126	\$ 157
7320	ALVEOPLASTY NOT IN CONJ WITH EXT. 4 OR MORE TEETH OR TOOTH SPACES PER QUAD	\$ 528	\$ 195	\$ 373
7510	INCISION AND DRAINAGE ABSCESS- INTRAORAL SOFT TISSUE	\$ 255	\$ 99	\$ 150
7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5CM	\$ 341	NO COST	\$ 210
7960	FRENLECTOMY (FRENECTOMY OR FRENOTOMY)- SEPARATE PROCEDURE	\$ 498	\$ 128	\$ 252
7970	EXCISION OF HYPERPLASTIC TISSUE- PER ARCH	\$ 582	\$ 207	\$ 341

<u>General Miscellaneous Services</u>				
9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN- MINOR PROCEDURE	\$ 138	\$ 48	\$ 54
9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE - FIRST 30 MINUTES	\$ 95	\$ 27	\$ 30
9310	CONSULTATION (DIAG. SERV. PROV. BY DENTIST OR PHYSICIAN OTHER THAN PRACTITIONER PROV. TREATMNT)	\$ 159	NO COST	\$ 114
9910	APPLICATION OF DESENSITIZING MEDICAMENT	\$ 73	\$ 6	\$ 24
9941	FABRICATION OF ATHLETIC MOUTHGUARD	\$ 315	\$ 107	\$ 86
9951	OCCLUSAL ADJUSTMENT-LIMITED	\$ 212	\$ 77	\$ 69
9952	OCCLUSAL ADJUSTMENT-COMplete	\$ 770	\$ 286	\$ 386
9999	MISSED APPOINTMENT (WITHOUT 24 HOUR NOTICE)	\$ 54	\$ 30	20% discount

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

Other Orthodontic Guidelines (These Orthodontic guidelines apply to the Alpha Dental Plan only)

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.

Alpha Dental Plan 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.

CarePOS Dental Plan General Limitations and Exclusions

This is a discount program. This is not an insurance plan. Beta Health cannot guarantee specialty care in all areas. In cases in which you are referred to a participating specialist, you will generally receive 15% to 20% off their usual and customary fees. Please verify such benefits with each individual provider. Work in progress, after joining the plan, must be completed by the provider who started the work. Any procedures performed by a non-participating provider are not included. Beta Health cannot guarantee the continued participation of any provider. If he or she leaves the plan, you will need to select another provider. Not all types of providers may be available in your area. Some providers may charge for missed or broken appointments if no prior notice is given. It is the member's responsibility to verify that the provider is a participating provider. This plan does not include all procedures which might be provided. Any procedure delivered which is not listed on the Schedule of Services may cause additional cost to be incurred by the member. The dollar amount specified adjacent to each procedure may not be the only cost incurred for a given treatment because the treatment may require more than one procedure. The program and the program administrators have no liability for providing or guaranteeing service and have no liability for the quality of service rendered. The most widely used dental procedures, discounted fees and limitations are illustrated. Please contact Beta Health Association, Inc. at (303) 744-3007 or 1-800-807-0706 with any questions. The CarePOS dental plan is marketed by Beta Health Association and administered by Careington International.



Please note:

**TO FIND A CONTRACTED Alpha or *CarePOS*
DENTIST IN
YOUR AREA VISIT:**

www.betadental.com and click on the “Provider Locator” link the “quick links” box. For CarePOS go to the Careington logo and click on the logo. Then enter your zip code.

**FOR THE FULL *CarePOS* FEE SCHEDULE IN
YOUR AREA VISIT:**

www.betadental.com and click on the “All Plan Fee Schedule” link in the “quick links” box. Then go to the Careington POS Fee Schedule box and enter your zip code. Your zip code specific fee schedule will appear in a PDF format. You will then be able to open the PDF file showing the discounted fees in your area.



PLANS #3 and #4

DENTAL INSURANCE PLAN

**To locate a
Delta provider please visit:**

www.betadental.com and click on the “Provider Locator” link the “quick links” box. Then go to the Delta logo and click. Select either PPO or Premier, enter your zip code and search parameters, and then click “search for a dentist”.

Benefits provided by:

 DELTA DENTAL®



Plans #3 and #4

Delta Dental Plan Highlights

Select Any Dentist

Preferred Networks Delta PPO and Premier

Deductibles to Satisfy

\$1000 to \$1500 Calendar year Maximum

Prevention First

Orthodontics (braces) for children and adults on Plan B only

Benefit waiting Periods may apply

Takeover credit also available initial enrollment only