

Helpful Hints



65 Wadsworth Park Dr. Ste. 202
 Draper, UT 84020
 (800) 999-9789

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

Preventive Services	Service	Frequency
	*Routine exams, cleanings	once every 6 months
	*Bitewing x-rays, Fluoride (child 14 and under)	
	Panoramic or Full mouth series x-rays	once every 36 months
	Periapical x- rays	1 initial, 12 additional 12 month period
Occlusal x-rays	once every 24 months	

* Services must be 6 months to the day apart to be eligible for coverage

Basic Services	Service	Frequency
	Non-routine exams, consultations.	
	Fillings (other than gold)	every 24 months
	*Endodontics (root canal therapy, pulpotomy, apicoectomy, apexification, retrograde fillings, pulpal therapy).	
	Oral surgery (extraction of tooth and tooth root, surgical exposure of tooth, alveoplasty, frenectomy, excision of pericoronal gingiva, reimplantation and repositioning of natural tooth, incision and drainage of intraoral abscess.	
Sealants on permanent unrestored molars & bicuspid (14 and under)	once every 36 months	
Space maintainers (14 and under)		

* Endodontics may be covered under major depending on the plan

Orthodontic Services	Service	
	Diagnostic records (cephalometric film, panoramic or full mouth x-rays, diagnostic casts, diagnostic photographs)	Children under 19 paid up to lifetime maximum
Removable, fixed or cemented appliance for orthodontic treatment including impressions, installations, & all adjustments while covered under the plan.	Bill monthly or quarterly	

Note: No coverage or limited coverage for orthodontic treatment that began prior to the effective date of coverage.

Limitations & Exclusions*	All Plans
	Drugs or the dispensing of drugs.
	Inlays, Onlays, Crowns on teeth that can be restored by direct placement materials.
	Replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
	Service
Composite or resin filling on molars & bicuspid (On Platinum plans only benefit reduced to amalgam benefit)	
Services to replace teeth that were missing (extracted or congenitally) prior to the effective date of coverage are not eligible for three years from effective date of continuous coverage.	

*This is not a complete list, please refer to the member's certificate booklet for a complete listing of all limitations and exclusions

Major Services	Service	Frequency
	Inlays, onlays, crowns, bridges, Complete or partial denture	every 5 years
	Occlusal guards for bruxism only	every 2 years
	Periodontics Root scaling/planing per quad	once every 24 months
	Periodontal maintenance (in lieu of preventive cleaning and three months after completion of periodontal treatment)	once every 6 months
	Periodontal surgery	every 36 months
	Full mouth debridement (to enable comprehensive evaluation every 5 years) <i>*Depending on the evaluation results, periodic cleanings, or periodontal procedures may be performed after debridement.</i>	
	*General Anesthesia Age 8 and over (in conjunction with covered oral surgery, based on necessity)	\$150 maximum per year
Age 7 and under	once per calendar year \$150 maximum	
* Not subject to waiting period		

Special Claims	Service	Submit to Dental Select with claim
	Anterior crowns/ two or more posterior crowns	x-rays
	Inlays and onlays/ multiple surface composites (2332,2335) / bridges, partials	x-rays
Scaling and root planing / periodontal maintenance / periodontal surgery	Periodontal charting Full mouth x-rays	

*The above services may require x-rays and or charting to be submitted with the claim. These services may be subject to review.