

These co-payments are the maximum fees that will be charged by the participating GENERAL DENTIST or SPECIALIST for the specified covered services.

DIAGNOSTIC

	<i>Member Pays</i>
0120 Periodic oral examination	No Charge
0140 Limited oral evaluation – problem focused. . . .	No Charge
0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
0150 Comprehensive oral evaluation.	No Charge
0160 Detailed and extensive oral evaluation – problem focused	No Charge
0170 Re-Evaluation - Problem Focused (Not Post-Operative Visit)	No Charge
0180 Comprehensive periodontal evaluation.	No Charge

X-RAYS AND TEST

0210/0330 Intraoral-periapical full mouth series or panoramic film (1 every 24 months)	No Charge
0220 Intraoral-periapical single film	No Charge
0230 Intraoral-periapical each add'l film	No Charge
0240 X-rays intraoral - occlusal film	No Charge
0260 Extraoral - each additional film	No Charge
0270 X-rays (bitewing) - single film	No Charge
0272 Bitewings 2 films	No Charge
0273 Bitewings 3 films	No Charge
0274 Bitewings 4 films	No Charge
0460 Pulp vitality test	No Charge
0470 Diagnostic casts and study models	No Charge
0502 Other oral pathology procedures, by report	No Charge

PREVENTIVE SERVICES

1110 Complete prophylaxis-adult (1 every 6 months)	No Charge
1120 Complete prophylaxis-child (1 every 6 months)	No Charge
1203/04 Fluoride treatment	No Charge
1330 Oral hygiene instruction	No Charge
1350/51 Sealants	No Charge
per quadrant, 3 or more teeth	No Charge
per tooth	No Charge
1510 Space maintainer (fixed unilateral)	No Charge
1111/21 Any additional prophylaxis (child/adult)	\$14
1202/06 Any additional fluoride treatment (child/adult) .	No Charge

MINOR RESTORATIVE SERVICES

2140 Amalgam-one surface (permanent)	No Charge
2150 Amalgam-two surfaces (permanent)	No Charge
2160 Amalgam-three surfaces (permanent)	No Charge
2161 Amalgam-four or more surfaces (permanent) . . .	No Charge
2330 Resin-one surface (anterior only, acid etch included)	No Charge
2331 Resin-two surfaces (anterior only, acid etch included)	No Charge
2332 Resin-three surfaces (anterior only, acid etch included)	No Charge
2335 Bonding (tooth reconstruction including incisal edge) (anterior only)	\$60
2390 Resin-based composite crown, anterior	\$90
2391 Resin-based composite - one surface, posterior	\$70
2392 Resin-based composite - two surfaces, posterior	\$90
2393 Resin-based composite - three surfaces, posterior	\$110
2394 Resin-based composite - four or more surfaces, posterior .	\$130

MAJOR RESTORATIVE SERVICES

	<i>Member Pays</i>
2740* Crown-porcelain	\$175
2750 Crown - porcelain fused to high noble metal	\$275+Lab
2751* Crown-porcelain fused to base metal	\$175
2752* Crown-porcelain fused to noble metal	\$175
2791* Crown-full cast base metal	\$175
2792* Crown-full cast noble metal	\$175

OTHER RESTORATIVE SERVICES

2910 Recement inlay (per unit)	No Charge
2920 Recement crown (per unit)	No Charge
2930 Crown-stainless steel (primary-child)	No Charge
2932 Crown-resin (prefabricated)	\$25
2940 Sedative restoration	No Charge
2951 Pin retention (per tooth, in addition to restoration)	No Charge
2954 Post (prefab) and core buildup (in addition to crown)	\$65
2970 Temporary crown (in conjunction with permanent crown)	No Charge

ENDODONTIC SERVICES*

3310 One canal per tooth	\$45
3320 Two canals per tooth	\$90
3330 Three or more canals per tooth	\$145
3220 Pulpotomy	No Charge
3410 Apicoectomy (anterior teeth only, includes retrograde fillings)	\$65

PERIODONTIC SERVICES*

4210 Gingivectomy or gingivoplasty (per quadrant)	\$90
4211 Gingivectomy or gingivoplasty - 1 to 3 teeth, per quadrant.	\$90
4240 Gingival flap, including root planing - 4 or more teeth, per quadrant.	\$220
4241 Gingival flap, including root planing - 1 to 3 teeth, per quadrant.	\$150
4260 Osseous surgery - 4 or more teeth or bounded spaces, per quadrant.	\$425
4261 Osseous surgery - one to three teeth, per quadrant . . .	\$250
4271 Free gingival graft (per procedure)	\$150
4341 Scaling and root planing (per quadrant, limit 4 per year)	\$40
4342 Periodontal root planing, one to three teeth (per quadrant, limit 4 per year)	\$40
4355 Full mouth debridement to allow evaluation and diagnosis	\$80

REMOVABLE PARTIAL AND FULL DENTURES

(Limited replacement to every 5 years)

5110 Complete upper denture (standard)	\$205
5120 Complete lower denture (standard)	\$205
5130 Immediate upper denture (standard)	\$225
5140 Immediate lower denture (standard)	\$225
5211/12 Partial upper or lower-acrylic, 2 clasps, 2 rests	\$195
5213/14 Partial upper or lower-chrome cast, 2 clasps, 2 rests . . .	\$240
5730/31 Reline complete upper or lower denture (office, 1 every 36 months)	No Charge
5740/41 Reline partial upper or lower denture (office, 1 every 36 months)	No Charge

MIAMI-DADE COUNTY & JACKSON HEALTH SYSTEM BENEFITS SCHEDULE

These co-payments are the maximum fees that will be charged by the participating GENERAL DENTIST or SPECIALIST for the specified covered services.

REMOVABLE PARTIAL AND FULL DENTURES *Member Pays*

5750/51	Reline or rebase complete upper or lower denture (laboratory, 1 every 36 months)	\$55
5760/61	Reline or rebase partial upper or lower denture (laboratory, 1 every 36 months)	\$55
5850	Soft tissue Conditioner.	No Charge
5410/11	Adjustments-complete upper or lower limit 3, new or existing	No Charge
	after 3, per adjustment.	\$3
5421/22	Adjustments-partial upper or lower limit 3, new or existing.	No Charge
	after 3, per adjustment	\$3

PROSTHETIC REPAIRS

5510	Complete upper or lower-broken no teeth damage.	No Charge
5520/21	Complete upper or lower replace one missing or broken tooth.	\$30
	each additional tooth (per tooth)	\$30
5640/41	Partial upper or lower replace one tooth	\$30
	each additional tooth (per tooth)	\$30
5650	Add tooth to partial denture to replace extracted tooth. .	\$30
5660	Repair or replace broken clasp with new clasp	\$30

FIXED BRIDGES

6241†	Bridge pontic-porcelain fused to base metal (per unit)	\$175
6242†	Bridge pontic-porcelain fused to noble metal (per unit)	\$175
6750	Crown - porcelain fused to high noble metal	\$275+Lab
6751	Crown – porcelain fused to predominately base metal .	\$175
6752†	Bridge abutment-porcelain fused to noble metal (per unit)	\$175
6545	Bonded Maryland bridge pontic (per unit).	\$175
6930	Recement bridge (per bridge)	No Charge

Cost of high noble metal additional.

†Per unit, up to six (6) units. Seven (7) or more units, add an additional \$40 per unit. Laboratory processed temporary splint, add an additional \$25 per unit for seven (7) or more units.

ORAL SURGERY*

7111	Coronal remnants – deciduous teeth	No Charge
7111	Coronal remnants – deciduous teeth, each additional tooth	No Charge
7140	Extraction, erupted tooth or exposed root	No Charge
7140	Extraction, erupted tooth or exposed root, each additional tooth	No Charge
7210	Surgical extraction of erupted tooth	No Charge

REMOVAL OF IMPACTED TOOTH – NOT COVERED UNLESS PATHOLOGY (DISEASE) EXISTS *Member Pays*

7220	Extraction-soft tissue impaction	\$20
7230	Extraction-partial bony impaction.	\$45
7240	Extraction-full bony impaction	\$70
7241	Removal of impacted tooth - completely bony, unusual Complications by report	\$200
7250	Surgical extraction of residual root (root recovery)	\$20
7471	Removal of lateral extosis	\$35
7999	Dry socket treatment	No Charge
7310/20	Alveolectomy or alveoloplasty (per quadrant)	\$25
7510	Incision and drainage of intra-oral abscess	No Charge
7970	Excision of hyperplastic tissue	No Charge
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons.	\$10
7960	Frenectomy	\$35
7999	Post operative treatment	No Charge

ORTHODONTICS*

8660	Pre-orthodontic treatment visit	No Charge
8999	Evaluation	\$25
8999	Orthodontic Treatment Plan and Records	\$200
8070/8080	Comprehensive Orthodontic Treatment of the Transitional/Adolescent Dentition Children up to 19 years of age Up to 24 months of routine orthodontic treatment for Class I and Class II cases.	\$1,400
8090	Comprehensive Orthodontic Treatment of the Adult Dentition up to 24 months of routine orthodontic treatment for Class I and Class II cases.	\$1,950

With participating orthodontists only. Cases under treatment are eligible for discounts at the sole discretion of the participating orthodontist.

MISCELLANEOUS

9110/20	Emergency treatment (palliative treatment for dental pain) during office hours	No Charge
	after office hours	\$25
9310	Consultation-second opinion (arranged by OHS and provided by a Participating Dentist)	No Charge
9440	Office visit – after regularly scheduled hours.	\$25
9630	Antimicrobial irrigation (per visit)	No Charge
9951	Occlusal adjustment (limited)	No Charge
9952	Occlusal equilibration (complete).	\$55
9940	Night guard (soft acrylic)	\$40
9940	Night guard (hard acrylic)	\$150
9999	Broken appointment (less than 24 hour notice)	\$10

*SPECIALIST CARE: This Benefits Schedule is valid at the Participating Specialist’s office when the patient is referred by the Participating General Dentist.

NOTE: Cosmetic procedures and procedures not listed on the Plan Benefits Schedule will be provided at the participating dentist’s usual, customary and reasonable (UCR) fees less 25%.

CERTIFICATE OF COVERAGE

CHOICE OF DENTIST

OHS contracts with established dentists in the community to provide quality care to our members. To receive benefits, you and your dependents must select a facility from the OHS list of participating dental offices. Dentists undergo a thorough review process prior to acceptance to our network. Each privately owned office is operated by a licensed general dentist and a staff of professional auxiliaries.

MAKING AN APPOINTMENT WITH YOUR DENTIST

You may schedule appointments by calling the dental office you selected after your effective date of coverage. There are no identification cards issued. When you call to schedule your appointment, notify the office that you are a member of the ORAL HEALTH SERVICES dental plan.

CHANGING YOUR SELECTION OF DENTIST

A situation may occur in which you need to change your dental office selection. Provider transfer requests may be in writing or may be made by calling our Member Support Department. Requests received during the first twenty (20) days of the month will become effective the first day of the following month. Requests received after the first twenty (20) days of the month will become effective the first of the month following the subsequent month. Any outstanding balance or pending appointments must be cleared up prior to requesting a transfer.

SPECIALIST CARE REFERRALS

Certain dental procedures require the services of a specialist (i.e. some oral surgery, endodontics, periodontics and pedodontics). In those cases, your general dentist will refer you to a participating specialist. You will be provided a referral form to present to the participating specialist to ensure proper coverage.

WHAT ARE CO-PAYMENT FEES?

Co-payments are reduced fees charged by the participating dental offices for some covered dental procedures as specified in the Benefits Schedule. The reduced fees are 60-75% less than the usual, customary and reasonable fees charged in a dental office. Members are financially responsible for copayment fees, payable to the dental office.

DEPENDENT ELIGIBILITY

Eligible dependents include the employee's spouse, unmarried children predominantly dependent upon the employee for support until the end of the month in which the child reaches the age of nineteen (19) or until the end of the calendar year in which the child reaches the age of twenty-five (25) provided the child continues to be predominately dependent upon the employee for support and resides in the employee's home or is registered as a full or part-time student as used herein, children shall include: all children born to you, whether pre-enrolled or not, from the moment of birth; children legally adopted by you from the moment of birth; children legally adopted by you from the moment of placement in your residence or if a newborn, from the moment of birth, if a written agreement to adopt has been entered into you prior to birth; or any stepchildren or foster children under you or your spouse's legal guardianship. Verification or proof of each unmarried child's support, residency and/or student status may be requested by OHS, whose determination of dependent eligibility shall be binding. Coverage will also be extended to any unmarried child over the age of nineteen (19) who is primarily dependent on the employee and otherwise incapable of self support by reason of mental or physical handicap. The employee must submit proof of dependency and incapacity within thirty (30) days of the dependent's attainment of age nineteen (19) and thereafter at the request of OHS for continued coverage.

TERMS OF ENROLLMENT

Enrollment in the OHS dental plan is for a minimum of twelve (12) consecutive months while employed by your current employer. Enrollment in the plan or changes to the plan will be allowed during the open enrollment periods as determined by your employer and OHS.

CANCELLING APPOINTMENTS

The time set aside for a patient is very valuable to the dentist. Therefore, if you cannot keep an appointment, notify the dental office at least 24 hours in advance. If you do not notify the office, charges will be made for broken appointment as stipulated in the Benefits Schedule.

EFFECTIVE DATE OF COVERAGE

The effective date of coverage is established between your employer and OHS. Upon enrollment you will be notified of your effective date of coverage.

EMERGENCY CARE WITHIN THE SERVICE AREA

In the event of an emergency, contact the participating OHS dental office you selected. If you are unable to reach your dentist, call the OHS 24-Hour Hotline and you will be instructed on how to receive necessary emergency dental care. OHS 24-Hour Emergency Hotline
Toll-Free: 800-380-3187

REIMBURSEMENT PROVISION FOR OUT-OF-AREA EMERGENCY CARE

Members and dependents are covered for emergency dental treatment to relieve pain or prevent worsening of an injury or unforeseen condition, such as a root canal, while temporarily more than fifty (50) miles from their participating dental office. In the event of an emergency, obtain treatment to relieve your pain/discomfort only from a licensed dentist and pay for the services rendered. To receive reimbursement you must submit to OHS within twelve (12) months of the date service was rendered, the following: 1) receipt; 2) member or dependent's name, social security number, address and phone number; 3) member/employee's name and social security number; and 4) all other supporting documentation necessary to process payment: Mail to:

Oral Health Services
P. O. Box 14283
Lexington, KY 40512-4283

OHS will reimburse no less than seventy-five percent (75%) of the usual, customary and reasonable charges for covered services subject to any applicable co-payments but in no event to exceed \$100.00 per claim.

SECOND OPINIONS

OHS can arrange for second opinions at no additional cost to the member. To coordinate second opinions, members should call OHS' Member Support Department at 1-800-380-3187. Second opinions not arranged and approved by OHS or rendered by a non-participating dentist will not be covered.

MEMBER SUPPORT AND GRIEVANCE PROCEDURE

OHS has the discretion to determine all benefits under this Certificate and to resolve all questions regarding the administration, interpretation and application of its terms. If a Member has a complaint or a grievance, the member must follow OHS' Grievance Procedures and grievances must be filed within one year of the date of the occurrence. Grievances can be handled informally by discussing the situation with an OHS representative of the Member Support Department at 1-800-380-3187 Monday through Friday, between hours of 8:00 a.m. and 5:00 p.m. Most grievances are resolved satisfactorily. However, in the event that a satisfactory resolution is not agreed upon, the Member may request resolution by filing a written grievance. Written grievances should be submitted to:

Oral Health Services, Inc.
Grievance and Appeals Department
P.O. Box 14729
Lexington, KY 40512-4729

Upon receipt, the written grievance will be reviewed by the Grievance and Appeals Department and the Department will respond in writing to the Member within thirty (30) days. In no event shall the elapsed time from the filing of grievance to the issuance of the written decision by the Department exceed Sixty (60) days. The decision of the Department will be binding unless the Member appeals the decision. If the Member declines to accept the decision of the Grievance and Appeals Department, the Member has thirty (30) days in which to file a formal written appeal of the decision. Upon receipt of the notice of appeal, the OHS Grievance and Appeals Committee will convene within fourteen (14) days to decide the appeal. The Member will be notified in writing within fourteen (14) days after the decision of the Grievance and Appeals Committee is reached. The determination by the Committee will be final and binding upon the Member and Provider. At any stage of the grievance process, the Member may file a complaint with the Florida Department of Insurance at:

Florida Department of Insurance
Consumer Assistance
200 East Gaines Street
Tallahassee, Florida 32399-0322

Or the Member may call the Florida Department of Insurance at 1-800-342-2762.

RENEWALS

Your coverage will automatically be renewed each year unless you notify your employer to terminate your coverage.

ADDITIONAL INFORMATION AVAILABLE

OHS shall make available to members, upon request, a description of the following:

- Authorization and referral process for covered dental services.
- Process used to analyze the qualifications and credentials of the dentist under contract with OHS.

EXCLUSIONS AND LIMITATIONS

The following dental benefits are not covered or offered under the plan:

- Oral surgery requiring the setting of fractures or dislocations.
- Treatment of congenital malformations.
- Treatment of malignancies.
- Dispensing of drugs.
- Any treatment requiring hospitalization.
- Any work which is not able to be performed because of the general health and physical limits of the eligible member, as indicated by said member's personal physician or the OHS dentist.
- Precision attachments or stress breakers.
- Replacement of partial or full dentures within two (2) years after installation unless resulting from the acts or omissions of OHS.
- Any treatment paid for by Worker's Compensation or covered or provided for by employer's liability laws, by a federal or state government agency, or provided without cost by any municipality, county or other political subdivision.
- Any procedure, implantation and/or any dental procedure considered to be experimental by the providing dentist.
- General anesthesia.
- Surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- Replacement of lost or stolen prosthetic devices.
- Any dental care provided by a non-participating general dentist or specialist, except when authorized by OHS.
- Services resulting from any act or war, declared or not, or resulting from military service.
- Charges for broken appointment are not covered.

The following limitations apply:

- The Participating Dentist shall have the right to refuse treatment to a member who fails to follow a prescribed course of treatment.
- Published member co-payments apply only when treatment is performed at a Participating Dental Office.
- If a member obtains dental services from other than a Participating Dentist/Specialist, the member shall be responsible for all costs.
- Members are eligible to receive any listed covered service on this Benefit Schedule when it has been determined that it is correct and appropriate care and has been prescribed by their OHS participating dentist.
- Not all participating dentists perform all listed procedures. Please consult your dentist prior to treatment for availability of services.
- Treatment in progress prior to the effective date of coverage is not covered, with the exception of orthodontic treatment.

COORDINATION OF BENEFITS

The benefits of this dental plan may be coordinated with an indemnity dental insurance plan. For information on coordination of benefits you should contact your indemnity dental insurance carrier.

GRACE PERIOD

Premiums are collected from Member on a bi-weekly basis for the preceding pay period for all coverage in effect during that pay period and remitted to OHS on a monthly basis. Although payment to OHS is due no later than the first of each month, Premiums must be paid no later than the expiration of the grace period, which is twenty (20) days after the first of each month. In the event a monthly Premium payment is not received by OHS prior to the expiration of the grace period, OHS, at its sole option, may terminate all coverage to the Group (or Member, as appropriate) effective as of the first day of the month following the month for which the Premium was due.

CERTIFICATE OF COVERAGE

TERMINATION OF MEMBERSHIP

Coverage for Member and each Dependent will cease the first day of the month following the day in which the Member's affiliation with Group is terminated, for any reason, and OHS receives written notice of the termination. If a Member permanently relocates from the OHS services area, or if OHS has no provider within twenty (20) miles of the Member's domicile, Member coverage will terminate. A Member may be entitled, upon written request to OHS, to a prorated refund of his/her prepaid Premium.

OHS may disenroll Member for any of the following reasons after forty-five (45) days notice and reasonable efforts to resolve any conflict through the use of the grievance procedure. OHS will make a reasonable effort to resolve the problem, including consideration of extenuating circumstances.

- a. A Member's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the Member's continuing participation would impair OHS' or a Provider's ability to provide covered Dental Services to the Member or to other Members;
- b. A Member commits fraud or makes a material misrepresentation in seeking Dental Services;
- c. A Member willfully misuses any documents provided as evidence of benefits available under this Agreement; or
- d. A Member furnishes to OHS, to any Participating Dentist, or to any insurance agent, broker or agency, incorrect or incomplete information for the purpose of fraudulently obtaining covered Dental Services.

Coverage for Dependents shall automatically terminate in the event the Member is disenrolled.

CONTINUATION OF BENEFITS

A Member and any Dependent of said Member whose coverage is terminated for any reason other than as set forth in Termination of Membership, may elect no later than sixty (60) days from the effective date of termination to continue coverage with OHS directly if he/she was enrolled in a OHS plan for at least three (3) successive months immediately preceding termination. Plan benefits available for continuation shall be similar to those then being offered by OHS to the group.

EXTENSION OF BENEFITS

OHS Providers shall complete all procedures commenced on Members prior to the effective date of termination to the extent that such Members would have been entitled to receive such Dental Services had this Agreement continued in effect, subject to the following conditions:

- a. During the period required for completion of such procedures, each Member shall continue to make the copayments required under the applicable Benefits Schedule.
- b. The term "procedures commenced on such Member prior to the date of termination" shall be construed to mean only those treatments and/or operative dental procedures actually commenced but unfinished, such as prosthetic appliances which have been cast and dentures commenced but unfinished prior to the effective date of termination of the Agreement. It shall not include dental defects which may have been diagnosed, but on which treatment or operative work may not have commenced, prior to the effective date of termination. Completion of dental procedures in progress of the effective date of termination will not exceed ninety (90) days after the effective date of termination.

DEFINITIONS

Diagnostic/Preventive

Prophylaxis: Cleaning, scaling and polishing procedure performed to remove coronal plaque, calculus, tartar and stains.
Sealant: Protective plastic covering which covers developmental grooves in healthy teeth to prevent decay. Space maintainer: An appliance inserted in the mouth to prevent drifting of teeth and the crowding of the erupted teeth.
Plaque: A sticky, colorless film of bacteria that forms on teeth, causing tooth decay, inflammation of the gums and disease.

Restorative (Fillings)

Amalgam: Silver filling, a metal alloy used in dental restoration primarily for posterior teeth.
Composite: White filling, a resin based material which is tooth colored used in dental restoration primarily for anterior teeth.
Acid etch: Use of a chemical substance to prepare the tooth surface to provide retention for bonding or composite restorations.

Fixed Crown and Bridge

Crown: A full artificial lab-fabricated thimble-like covering of the visible part of a tooth down to the gum line used to restore a tooth to its original structure; also called a "cap".
Base metal: Non-precious metal alloy used in the fabrication of crowns.
Noble metal: Semi-precious metal alloy used in the fabrication of crowns.
High Noble metal: Gold metal alloy used in the fabrication of crowns.
Post: A small metal post usually inserted into the tooth canal after root canal therapy to strengthen the tooth prior to making a crown.
Bridge (Fixed): A prosthetic replacement of one or more missing teeth which is cemented to the abutment teeth adjacent to the space.

Pontic: The part of a fixed bridge suspended between abutments which replaces a missing tooth or teeth; "false tooth."
Abutment: The tooth adjacent to the missing tooth or teeth that supports or holds a fixed bridge

Bonding: White tooth-colored light-cured material used to strengthen a tooth or to enhance the cosmetic appearance of a tooth. This material is sometimes used for dental restorations on both anterior and posterior teeth.
Maryland bridge: Porcelain resin bonded bridge designed to replace missing teeth with minimal preparation of adjacent healthy teeth.

Endodontics (Root Canal Therapy)

Pulp: The blood vessels and nerve tissue that occupy the pulp cavity of a tooth.
Pulpotomy: Removal of the coronal portion of the pulp.
Root canal therapy: Treatment and removal of the pulp cavity inside the root of a tooth to eliminate disease and to promote healing and repair of tissue.
Apicoectomy: Surgical amputation procedure of the root end of a tooth.

Oral Surgery (Extractions)

Impacted tooth: An unerupted or partially erupted tooth positioned against another tooth, bone, or soft tissue not allowing complete and normal eruption.
Dry socket: Inflammation of the tooth socket following an extraction due to the infection or loss of blood clot.
Exostosis: Overgrowth of normal bone.
Alveoloplasty: Surgical procedure for recontouring bone structure, usually in preparation for a prosthesis.
Frenectomy: Cutting of the tissue that stretches between the lip and the gumline or the tissue attaching the tongue to the floor of the mouth.

Periodontics (Gum Treatment)

Periodontics: The treatment of gum and bone tissue which surround and support the teeth.
Scaling: Removal of plaque, calculus, tartar and stain from teeth.
Root planing: Treatment of periodontal disease which consists of smoothing the root surface below the gum line to promote healing conditions without surgical treatment.
Curettage: Treatment which consists of scraping and cleaning the walls of the gingival pocket tissue. This procedure is also performed in conjunction with root planning.
Gingivectomy: Surgical removal of the flaps of gum tissue that create pockets alongside periodontally damaged teeth.
Gingival graft: A piece of transplanted tissue placed in contact with marginal gum tissue to repair a defect or supplement a deficiency area.
Osseous surgery: Surgical procedure of the bone which is utilized to improve and maintain periodontal condition.
Occlusal adjustment: Adjustments done to bring the upper and lower teeth (bite) into proper contact.
Night guard: U-shaped removable appliance made from plastic, latex or other material fitted to the teeth for protection.

Prosthetics (Full & Partial Dentures)

Denture: A removable dental prosthetic appliance used to replace all of the missing natural teeth.
Immediate denture: A full denture that is made from a mold of the patient's teeth and inserted immediately after the extraction of those teeth.
Partial Denture: A removable dental prosthetic appliance which replaces one or more missing natural teeth.
Reline: To resurface the inside of a denture or partial.
Rebase: A process of refitting a denture or partial by replacing the base material.