UnitedHealthcare®
dental plan

Select Managed Care-DC Contributory CA/$0/$0/$5/CA240
CA D1064

SMC/covered dental services

ADA	DESCRIPTION	MEMBER PAYS
DIAGNOSTIC SERVICES		
D0120	PERIODIC ORAL EVALUATION EST PT	$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$0
D0145	ORAL EVAL PT<3 AND COUNSEL	$0
D0150	COMP ORAL EVALUATION - NEW/EST PT	$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS REPORT	$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	$0
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE VISIT	$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0210	INTRAORAL – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES	$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$0
D0230	INTRAORL PERIAPICAL EACH ADD RADIOGRAPHIC IMAGE	$0
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$0
D0251	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$10
D0364	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$10
D0365	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$10
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$15
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$15
D0368	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$20
D0372	INTRAORAL TOMOSYNTHESIS–COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES	$0
D0373	INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE	$0
D0374	INTRAORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE	$0
D0387	INTRAORAL TOMOSYNTHESIS–COMPREHENSIVE SERIES OF RADIOGRAPHIC–IMAGE CAPTURE ONLY	$0
D0388	INTRAORAL TOMOSYNTHESIS–BITEWING RADIOGRAPHIC–IMAGE CAPTURE ONLY	$0
D0389	INTRAORAL TOMOSYNTHESIS–PERIAPICAL RADIOGRAPHIC–IMAGE CAPTURE ONLY	$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	$5
D0414	LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0
D0415	COLLECT MICROORGANISMS CULT & SENS	$0
D0416	VIRAL CULTURE	$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	$0
D0418	ANALYSIS OF SALIVA SAMPLE	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$0
D0460	PULP VITALITY TESTS	$0
D0470	DIAGNOSTIC CASTS	$0
D0472	ACCESS TISSUE, GROSS EXAM - PREP & REPORT	$0
D0473	ACCESS TISSUE, GROSS & MICROSCOPIC - PREP/REPORT	$0
D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	$0
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$0
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$0
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$0
D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	$0
D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	$0
D0705	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0706	INTRAORAL–OCCLUSAL RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0707	INTRAORAL–PERIAPICAL RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	$0
D0708	INTRAORAL–BITEWING RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0709	INTRAORAL–COMPREHENSIVE SERIES OF RADIOGRAPHIC–IMAGE CAPTURE ONLY	$0
PREVENTIVE SERVICES		
D1110	PROPHYLAXIS - ADULT	$0
D1120	PROPHYLAXIS - CHILD	$0
D1206	TOPICALFLUORIDE VARNISH	$0
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$0
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	$0
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	$0
D1330	ORAL HYGIENE INSTRUCTIONS	$0
D1351	SEALANT - PER TOOTH	$0
D1352	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$0

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PREVENTIVE SERVICES		
D1353	SEALANT REPAIR – PER TOOTH	$0
D1355	CARIES PREVENTIVE MEDICAMENT APPLICATION – PER TOOTH	$0
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	$0
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	$0
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	$0
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	$0
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	$0
D1551	RECEM/REBOND BILATERAL SPACE MAINTAINER – MAXIL	$0
D1552	RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB	$0
D1553	RECEM/REBOND UNILATERAL SPACE MAINTAINER/QUAD	$0
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER/QUAD	$0
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	$0
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	$0
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED, UNILATERAL/QUAD	$0
RESTORATIVE SERVICES		
D2140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	$5
D2150	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	$5
D2160	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	$10
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	$10
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	$5
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	$5
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	$10
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	$10
D2390	RESIN COMPOSITE CROWN ANTERIOR	$20
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	$5
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	$10
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	$10
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	$10
D2510	INLAY - METALLIC - ONE SURFACE	$95
D2520	INLAY - METALLIC - TWO SURFACES	$95
D2530	INLAY - METALLIC - 3/MORE SURFACES	$95
D2542	ONLAY - METALLIC - TWO SURFACES	$95
D2543	ONLAY - METALLIC THREE SURFACES	$95
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	$95
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	$35
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$40
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	$45
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$95
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	$95
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	$95
D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	$30
D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	$35
D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	$40
D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	$30
D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	$40
D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	$45
D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	$20
D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	$20
D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	$40*
D2721	CROWN - RESIN W/PREDOM BASE METAL	$30
D2722*	CROWN - RESIN WITH NOBLE METAL	$30*
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$100
D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	$100*
D2751	CROWN - PORCELAIN FUSED PREDOM BASE METAL	$90
D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	$100*
D2753	CROWN PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$100
D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	$95*
D2781	CROWN - 3/4 CAST PREDOM BASE METAL	$90
D2782*	CROWN - 3/4 CAST NOBLE METAL	$95*
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$95
D2790*	CROWN - FULL CAST HIGH NOBLE METAL	$100*
D2791	CROWN - FULL CAST PREDOM BASE METAL	$90
D2792*	CROWN - FULL CAST NOBLE METAL	$100*
D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	$100*
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$5
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFABRICATED POST & CORE	$5
D2920	RECEMENT OR RE-BOND CROWN	$5
D2921	REATTACHMENT OF TOOTH FRAGMENT	$5
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	$10
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	$10
D2932	PREFABRICATED RESIN CROWN	$10
D2933	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	$10
D2934	PREFABRICATED ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	$10
D2940	SEDATIVE FILLING	$5
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$5
D2950	CORE BUILDUP INCLUDING ANY PINS	$5
D2951	PIN RETENTION - PER TOOTH ADDITION REST	$5
D2952	POST & CORE ADD CROWN INDIRECT FAB	$25
D2953	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	$5
D2954	PREFABRICATED POST & CORE ADDITION CROWN	$10

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RESTORATIVE SERVICES		
D2955	POST REMOVAL	$20
D2957	EACH ADD PREFABR POST - SAME TOOTH	$5
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	$20
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	$40
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	$40
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER XST PART DENTURE	$10
D2975	COPING	$70
D2980	CROWN REPAIR	$15
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$0
D3120	PULP CAP - INDIRECT	$0
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL JUNC	$0
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT TEETH	$5
D3222	PARTIAL PULPOTOMY	$0
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$0
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$0
D3310	ANTERIOR	$15
D3320	BICUSPID	$20
D3330	MOLAR	$60
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$5
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$0
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$5
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$15
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$20
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$35
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	$5
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	$5
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$10
D3355	PULPAL REGENERATION - INITIAL VISIT	$5
D3356	PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT	$5
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	$10
D3410	APICOECTOMY SURG - ANT	$15
D3421	APICOECTOMY SURG-BICUSPID	$20
D3425	APICOECTOMY SURG - MOLAR	$30
D3426	APICOECTOMY SURGERY	$10
D3430	RETROGRADE FILLING - PER ROOT	$10
D3450	ROOT AMPUTATION - PER ROOT	$12
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	$15
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR	$20
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	$30
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR	$13
D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–PREMOLAR	$13
D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–MOLAR	$13
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$5
D3911	INTRAORIFICE BARRIER	$5
D3920	HEMISECTION NOT INCL RC THERAPY	$5
D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	$5
PERIODONTIC SERVICES		
D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	$10
D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	$5
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$10
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$5
D4245	APICALLY POSITIONED FLAP	$10
D4249	CLIN CROWN LEN - HARD TISSUE	$10
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$30
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$20
D4263	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	$15
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$10
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$10
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$15
D4322	SPLINT–INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	$10
D4323	SPLINT–EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	$5
D4341	PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD	$5
D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	$5
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$0
D4355	FULL MOUTH DEBRID COMP PERIODONTAL EVAL & DX	$5
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$5
D4910	PERIODONTAL MAINTENANCE	$0
D4920	UNSCHEDULED DRESSING CHANGE	$0
D4921	GINGIVAL IRRIGATION WITH A MEDICINAL AGENT–PER QUAD	$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110	COMPLETE DENTURE - MAXILLARY	$140
D5120	COMPLETE DENTURE - MANDIBULAR	$140
D5130	IMMEDIATE DENTURE - MAXILLARY	$140
D5140	IMMEDIATE DENTURE - MANDIBULAR	$140
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	$40
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$40
D5213	MAX PART DENTUR-CAST METL W/RSN	$140
D5214	MAND PART DENTUR- CAST METL W/RSN	$140

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REMOVABLE PROSTHODONTIC SERVICES		
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$30
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$30
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$30
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$30
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$40
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	$40
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX BASE	$30
D5228	IMMEDIATE MANDIBULAR PARTIAL DENTURE-FLEX BASE	$30
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE - MAXILLARY	$20
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	$20
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE – FLEX BASE/QUAD	$40
D5286	REMOVABLE UNILATERAL PARTIAL DENTURE-RESIN/QUAD	$40
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$5
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$5
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$5
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$5
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	$10
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$10
D5520	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$5
D5611	REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	$10
D5612	REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	$10
D5621	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$25
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$25
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$25
D5640	REPLACE BROKEN TEETH - PER TOOTH	$10
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$10
D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$20
D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK MAXILLARY	$45
D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK MANDIBULAR	$45
D5710	REBASE COMPLETE MAXILLARY DENTURE	$40
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$40
D5720	REBASE MAXILLARY PARTIAL DENTURE	$30
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$30
D5725	REBASE HYBRID PROSTHESIS	$40
D5730	RELINE CMPL MAXIL DENTURE (DIRECT)	$25
D5731	RELINE CMPL MAND DENTURE (DIRECT)	$25
D5740	RELINE MAXIL PART DENTURE (DIRECT)	$20
D5741	RELINE MAND PART DENTURE (DIRECT)	$20
D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	$30
D5751	RELINE CMPL MAND DENTURE (INDIRECT)	$30
D5760	RELINE MAXIL PART DENTURE (INDIRECT)	$30
D5761	RELINE MAND PART DENTURE (INDIRECT)	$30
D5765	SOFT LINER FOR COMPLETE OR PART REMOVABLE DENTURE–INDIRECT	$5
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$40
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$40
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$30
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$30
D5850	TISSUE CONDITIONING MAXILLARY	$5
D5851	TISSUE CONDITIONING MANDIBULAR	$5
D5863	OVERDENTURE - COMPLETE MAXILLARY	$140
D5864	OVERDENTURE - COMPLETE MANDIBULAR	$140
D5865	OVERDENTURE - PARTIAL MAXILLARY	$140
D5866	OVERDENTURE - PARTIAL MANDIBULAR	$140
D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE (PER ARCH)	$40
IMPLANT SERVICES		
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,950
D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	$1,950
D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	$540
D6056	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$368
D6057	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$610
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,050
D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$915*
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$1,050
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$946*
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$981*
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$854
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$1,168*
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,144
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$1,083*
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	$962*
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$1,026

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IMPLANT SERVICES		
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$1,050
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$965
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$984*
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$997*
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$910
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$967*
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$1,018
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$992*
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	$962*
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$55
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	$15
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$1,083
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS	$1,083
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$1,083
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE ALLOYS	$962
D6087	IMPLANT SUPPT CROWN-NOBLE ALLOYS	$962
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM ALLOYS	$962
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$135
D6091	REPLCMT OF REPLCEABLE PART OF SEMI-PRECISION/PRECISION ATTCHMT OF IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER ATTCHMT	$410
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	$79
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$124
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	$810*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$55
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$20
D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$915
D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$992
D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	$992
D6100	SURGICAL REMOVAL OF IMPLANT BODY	$600
D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$15
D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$50
D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	$350
D6105	REMVL OF IMPLANT BODY NOT REQUIR BONE REMVL/FLAP ELEVATION	$5
D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$1,840
D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$1,840
D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$1,840
D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$1,840
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$40
D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$40
D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$992
D6121	IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS	$962
D6122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	$962
D6123	IMPLANT SUPPT RETAINER FOR METAL FPD-TITANIUM/TITANIUM ALLOYS	$962
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$265
D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	$368
D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	$368
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	$835
D6195	ABUTMENT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$1,050
D6197	REPLCMNT OF RESTOR MATERIAL TO CLOSE ACCESS OPENING OF SCREW-RETAIN IMPLANT SUPPT PROSTHESIS, PER IMPLANT	$5
FIXED PROSTHODONTIC SERVICES		
D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	$20
D6210*	PONTIC - CAST HIGH NOBLE METAL	$80*
D6211	PONTIC - CAST PREDOM BASE METAL	$75
D6212*	PONTIC - CAST NOBLE METAL	$80*
D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	$80*
D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	$80*
D6241	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	$75
D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	$80*

ADA	DESCRIPTION	MEMBER PAYS
FIXED PROSTHODONTIC SERVICES		
D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$80
D6245	PONTIC - PORCELAIN/CERAMIC	$95
D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	$25*
D6251	PONTIC RESIN W/PREDOM BASE METAL	$15
D6252*	PONTIC RESIN W/NOBLE METAL	$15*
D6253	INTERIM PONTIC–FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	$25
D6545	RETAINER - CASE METAL FOR RESIN FIXED PROSTHESIS	$10
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	$10
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	$10
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2 SURFACES	$40
D6601	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$45
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	$40*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	$45*
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	$40
D6605	RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES	$45
D6606*	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$40*
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	$45*
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	$45
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$50
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	$55*
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	$60*
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	$50
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	$55
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$50*
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	$50*
D6624*	RETAINER INLAY - TITANIUM	$45*
D6634*	RETAINER ONLAY - TITANIUM	$75*
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$20
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$40*
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$30
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	$30*
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$100
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$100*
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$90
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$100*
D6753	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$100
D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$95*
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$90
D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	$95*
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$95
D6784	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	$95
D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$100*
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$90
D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	$100*
D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	$100*
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$5
D6940	STRESS BREAKER	$5
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$20
ORAL SURGERY SERVICES		
D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	$5
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$5
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$5
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$10
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$20
D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	$15
D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	$25
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$5
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$10
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	$10
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$10
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	$5
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$5
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$5
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$5
D7288	BRUSH BIOPSY	$5
D7290	SURGICAL REPOSITIONING OF TEETH	$10
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$5
D7311	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	$5
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$10
D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	$5
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$20

ADA	DESCRIPTION	MEMBER PAYS
ORAL SURGERY SERVICES		
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$30
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$20
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$30
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$20
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$30
D7471	REMOVAL OF LATERAL EXOSTOSIS	$15
D7472	REMOVAL OF TORUS PALATINUS	$30
D7473	REMOVAL OF TORUS MANDIBULARIS	$15
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$25
D7509	MARSUPIALIZATION OF ODONTOGENIC CYST	$20
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	$5
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	$5
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$10
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$10
D7530	REMOVAL OF FOREIGN BODY - SKIN SUBCUTANEOUS	$5
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	$5
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	$5
D7963	FRENULOPLASTY	$5
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$10
D7971	EXCISION OF PERICORONAL GINGIVA	$10
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$20
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATIVE TREATMENT OF DENTAL PAIN – PER VISIT	$5
D9120	FIXED PARTIAL DENTURE SECTIONING	$15
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$0
D9211	REGIONAL BLOCK ANESTHESIA	$0
D9212	TRIGEMINAL DIVISION BLOCK ANES	$0
D9215	LOCAL ANESTHESIA	$0
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	$0
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	$10
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$5
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$5
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$10
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$5
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$5
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$0
D9430	OV OBS - NO OTH SERVICES PERFORMED	$0
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$5
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9943	OCCLUSAL GUARD ADJUSTMENT	$5
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	$15
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	$15
D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH	$15
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$5
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$5
D9972	EXTERNAL BLEACHING - PER ARCH PERFORMED IN OFFICE	$125
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME ENCOUNTER	$0
D9996	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW	$0
ORTHODONTIC SERVICES		
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$1,500
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$1,500
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$1,500
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	$0
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	$150
D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF TREATMENT	$75
D8999	a START-UP FEE (INCLUDING EXAM, BEGINNING RECORDS, X-RAYS,TRACING, PHOTOS, AND MODELS)	$350

For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.

*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed $150 per unit. If a base metal is used, there are no additional charges from the provider.

UnitedHealthcare/Select Managed Care dental exclusions and limitations

LIMITATIONS OF BENEFITS

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefit

1.	DENTAL PROPHYLAXIS	Limited to 1 time per 6 months
2.	FLUORIDE TREATMENTS	Limited to 1 time per 6 months
3.	INLAYS, ONLAYS, AND VENEERS	Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
4.	CROWNS	Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
5.	POST AND CORES	Covered only for teeth that have had root canal therapy.
6.	SCALING AND ROOT PLANING	Limited to 4 quadrants per calendar year.
7.	REPLACEMENT OF COMPLETE DENTUR FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROTHESIS	Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implants, implant crowns, implant prosthesis previously submitted for payment under the plan is limited to 1 time per tooth per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances. If damage or breakage was directly related to provider error, this type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
8.	INTRAORAL BITEWING RADIOGRAPHS	Limited to 1 series of 4 films in any 6 month period
9.	STAINLESS STEEL CROWNS	Limited to 1 time per tooth per 60 Months. Covered only when a filing cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.
10.	ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS	Limited to repairs or adjustments performed more than 6 months after the initial insertion.
11.	INTRAVENOUS SEDATION OR GENERAL ANESTHESIA	Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).
12.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's Participating Dentist. Any Covered Person who elects specialist care without prior referral by his or her Participating Dentist and approval by us is responsible for all charges incurred. • In order for specialty services to be Covered by this plan, the following referral process must be followed: • A Covered Person's Participating Dentist must coordinate all Dental Services. • When the care of a Network Specialist Dentist is required, the Covered Person's Participating Dentist must contact us and request authorization. • If the Participating Dentist request for specialist referral is denied, the Participating Dentist and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the Participating Dentist may be asked to perform the service. • Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services. • Covered Person's fi nancial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.
13.	PERIODONTAL MAINTENANCE PROCEDURES	Limited to once every 6 months, following active therapy, exclusive of gross debridement
14.	REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (MINOR RESTORATIVE SERVICES)	Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 years from initial or supplemental placement
15.	CROWNS, FIXED BRIDGES, AND IMPLANTS	The maximum benefit within a 12-month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12-month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Changes.
16.	ADJUNCTIVE	Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesion, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
17.	INTRAORAL	Complete Series (including bitewings) - Limited to 1 time in any 2-year period
18.	TEMPORARY CROWNS	Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
19.	CONE BEAM	Limited to 1 time per consecutive 60 months.

LIMITATIONS OF BENEFITS

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefit

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EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1.	Dental Services that are not Necessary.
2.	Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
3.	Any Dental Procedure not directly associated with dental disease.
4.	Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
5.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
6.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
7.	Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
8.	Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
9.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
10.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
11.	Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
12.	Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
13.	Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
14.	Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Primary Care Dentist, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
15.	Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
16.	Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
17.	Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by a Participating Dentist; or (b) treatment by a specialist without referral from a Participating Dentist and our approval.
18.	Any Dental Procedure not performed in a dental setting. This will not apply to Covered Emergency Dental Services.
19.	Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
20.	Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare
21.	Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

22. Orthodontic Exclusions & Limitations

If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the Covered Person will be responsible for all costs associated with any orthodontic treatment. Orthodontic services Copayments are valid for authorized services rendered. If you terminate Coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

Orthodontic Exclusions:

a) Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person

b) Treatment in progress prior to the effective date of this coverage

c) Extractions required for orthodontic purposes

d) Surgical orthodontics or jaw repositioning

e) Myofunctional therapy

f) Cleft palate

g) Micrognathia

h) Macroglossia

i) Hormonal imbalances

j) Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of treatment of accident

k) Palatal expansion appliances

l) Services performed by outside laboratories

Orthodontic Limitations:

1. If a treatment plan is for less than 24 months, then a prorated portion of the full copayment shall apply.

2. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.

3. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist.

4. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this Comprehensive Orthodontic Treatment. If comprehensive treatment is necessary, and is completed within a 24 month period, the Copayments listed will apply. If necessary and active treatment extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.

