UnitedHealthcare®
DHMO/Managed Care Contributory Santa Cruz 150/covered dental services

dental plan
CA D125H

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	$5
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0190	SCREENING OF A PATIENT	$5
D0191	ASSESMENT OF A PATIENT	$5
D0210	INTRAORAL - COMPLETE SERIES 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	$50
D0364	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$20
D0365	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$20
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$25
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$30
D0368	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$35
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	$10
D0417	COLLECTION & PREP OF SALIVA SAMPLE	$10
D0418	ANALYSIS OF SALIVA SAMPLE	$10
D0422	COLLECTION AND PREPARATION OF GENETIC SAMPLE MATERIAL FOR LABORATORY ANALYSIS AND REPORT	$0
D0423	GENETIC TEST FOR SUSCEPTIBILITY TO DISEASES - SPECIMEN ANALYSIS	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$20
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–COMPLETE SERIES OF RADIOGRAPHIC IMAGES–IMAGE CAPTURE ONLY	$0
D0999	OFFICE VISIT FEE - PER VISIT	$0
PREVENTIVE SERVICES		
D1110[1]	PROPHYLAXIS - ADULT	$0
D1110[1]	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	$25
D1120[1]	PROPHYLAXIS - CHILD	$0
D1120[1]	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6 MONTHS	$25
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	$5
D1352	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$10
D1353	SEALANT REPAIR – PER TOOTH	$5
D1355	CARIES PREVENTIVE MEDICAMENT APPLICATION – PER TOOTH	$0
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	$15
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	$15
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	$20
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	$20
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	$20
D1551	RECEM/REBOND BILATERAL SPACE MAINTAINER – MAXIL	$0
D1552	RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB	$0

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PREVENTIVE SERVICES		
D1553	RECEM/REBOND UNILATERAL SPACE MAINTAINER/QUAD	$0
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER/QUAD	$10
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	$10
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	$10
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED, UNILATERAL/QUAD	$15
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT	$0
RESTORATIVE SERVICES		
D2140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	$0
D2150	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	$0
D2160	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	$0
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	$0
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	$0
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	$0
D2390	RESIN COMPOSITE CROWN ANTERIOR	$20
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	$25
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	$35
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	$45
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	$45
D2510	INLAY - METALLIC - ONE SURFACE	$115
D2520	INLAY - METALLIC - TWO SURFACES	$115
D2530	INLAY - METALLIC - 3/MORE SURFACES	$115
D2542	ONLAY - METALLIC - TWO SURFACES	$115
D2543	ONLAY - METALLIC THREE SURFACES	$115
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	$115
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	$125*
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$125*
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	$125*
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$125*
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	$125*
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	$125*
D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	$125
D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	$125
D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	$125
D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	$125
D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	$125
D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	$125
D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	$90
D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	$90
D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	$125*
D2721	CROWN - RESIN W/PREDOM BASE METAL	$125*
D2722*	CROWN - RESIN WITH NOBLE METAL	$125*
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$215*
D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	$125*
D2751	CROWN - PORCELAIN FUSED PREDOM BASE METAL	$125*
D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	$125*
D2753	CROWN PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$125
D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	$125*
D2781	CROWN - 3/4 CAST PREDOM BASE METAL	$125*
D2782*	CROWN - 3/4 CAST NOBLE METAL	$125*
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$125*
D2790*	CROWN - FULL CAST HIGH NOBLE METAL	$125*
D2791	CROWN - FULL CAST PREDOM BASE METAL	$125*
D2792*	CROWN - FULL CAST NOBLE METAL	$125*
D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	$125*
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$0
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFABRICATED POST & CORE	$0
D2920	RECEMENT OR RE-BOND CROWN	$0
D2921	REATTACHMENT OF TOOTH FRAGMENT	$65
D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	$80*
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	$20
D2934	PREFABRICATED ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	$60
D2940	SEDATIVE FILLING	$0
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$5
D2950	CORE BUILDUP INCLUDING ANY PINS	$10
D2951	PIN RETENTION - PER TOOTH ADDITION REST	$8
D2952	POST & CORE ADD CROWN INDIRECT FAB	$20
D2953	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	$10
D2954	PREFABRICATED POST & CORE ADDITION CROWN	$10
D2955	POST REMOVAL	$10
D2957	EACH ADD PREFABR POST - SAME TOOTH	$15
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	$270
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	$465*
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	$560*
D2971	ADD PROCEDURE NEW CROWN XST PART DENTURE	$25
D2975	COPING	$80
D2980	CROWN REPAIR	$45
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$5
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	$60
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$5
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$5
D3310	ANTERIOR	$45
D3320	BICUSPID	$75
D3330	MOLAR	$115
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$65
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$45
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$45
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$70

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ENDODONTIC SERVICES		
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$100
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$140
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	$50
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	$45
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$45
D3355	PULPAL REGENERATION - INITIAL VISIT	$65
D3356	PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT	$65
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	$65
D3410	APICOECTOMY SURG - ANT	$75
D3421	APICOECTOMY SURG-BICUSPID	$75
D3425	APICOECTOMY SURG - MOLAR	$75
D3426	APICOECTOMY SURGERY	$35
D3430	RETROGRADE FILLING - PER ROOT	$35
D3450	ROOT AMPUTATION - PER ROOT	$75
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$970
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	$75
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR	$75
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	$75
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR	$250
D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–PREMOLAR	$250
D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–MOLAR	$250
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$15
D3920	HEMISECTION NOT INCL RC THERAPY	$75
D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	$15
PERIODONTIC SERVICES		
D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	$50
D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	$35
D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST PROC/TOOTH	$15
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$115
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$85
D4245	APICALLY POSITIONED FLAP	$155
D4249	CLIN CROWN LEN - HARD TISSUE	$115
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$225
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$155
D4263	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	$175
D4264	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – EACH ADDITIONAL SITE IN QUADRANT	$75
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$195
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$50
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$235
D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH	$275
D4320	PROVISIONAL SPLINTING - INTRACORONAL	$75
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$75
D4341	PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD	$25
D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	$15
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$15
D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX ON A SUBSEQUENT VISIT	$25
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$55
D4910	PERIODONTAL MAINTENANCE	$15
D4920	UNSCHEDULED DRESSING CHANGE	$0
D4921	GINGIVAL IRRIGATION PER QUADRANT	$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110	COMPLETE DENTURE - MAXILLARY	$150*
D5120	COMPLETE DENTURE - MANDIBULAR	$150*
D5130	IMMEDIATE DENTURE - MAXILLARY	$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	$150*
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	$115*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$115*
D5213	MAX PART DENTUR-CAST METL W/RSN	$165*
D5214	MAND PART DENTUR- CAST METL W/RSN	$165*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$45*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$45*
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$45*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$45*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$325*
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	$325*
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE - MAXILLARY	$150*
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	$150*
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE – FLEX BASE/QUAD	$325
D5286	REMOVABLE UNILATERAL PARTIAL DENTURE-RESIN/QUAD	$325
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$0
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$0
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$0
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$0
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	$15*
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$15*
D5520	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$15*
D5611	REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	$15*
D5612	REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	$15*
D5621	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$15*
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$15*
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$15*
D5640	REPLACE BROKEN TEETH - PER TOOTH	$15*
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$15*

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REMOVABLE PROSTHODONTIC SERVICES		
D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$15*
D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK MAXILLARY	$125*
D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK MANDIBULAR	$125*
D5710	REBASE COMPLETE MAXILLARY DENTURE	$45*
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$45*
D5720	REBASE MAXILLARY PARTIAL DENTURE	$45*
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$45*
D5730	RELINE CMPL MAXIL DENTURE (DIRECT)	$0*
D5731	RELINE CMPL MAND DENTURE (DIRECT)	$0*
D5740	RELINE MAXIL PART DENTURE (DIRECT)	$0*
D5741	RELINE MAND PART DENTURE (DIRECT)	$0*
D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	$40*
D5751	RELINE CMPL MAND DENTURE (INDIRECT)	$40*
D5760	RELINE MAXIL PART DENTURE (INDIRECT)	$40*
D5761	RELINE MAND PART DENTURE (INDIRECT)	$40*
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$45*
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$45*
D5850	TISSUE CONDITIONING MAXILLARY	$10
D5851	TISSUE CONDITIONING MANDIBULAR	$10
D5863	OVERDENTURE - COMPLETE MAXILLARY	$425
D5864	OVERDENTURE - COMPLETE MANDIBULAR	$450
D5865	OVERDENTURE - PARTIAL MAXILLARY	$425
D5866	OVERDENTURE - PARTIAL MANDIBULAR	$450
D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE (PER ARCH)	$45
IMPLANT SERVICES		
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,035
D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	$1,185
D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	$390
D6056	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$290
D6057	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$395
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$710
D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$710
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$575
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$635
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$675
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$595
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$620
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$740
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$720
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	$730
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$680
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$705
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$630
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$680
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$690
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$630
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$670
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$740
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$705
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	$665
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$80
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	$190
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$720
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS	$720
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$720
D6085	PROVISIONAL IMPLANT CROWN	$55
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE ALLOYS	$730
D6087	IMPLANT SUPPT CROWN-NOBLE ALLOYS	$730
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM ALLOYS	$730
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$130
D6091	REPLACEMT OF REPLACEABLE PT OF SEMI-PRECISION/PRECISION ATTACHMT OF IMPLANT/ABUTMENT SUPPORT PROSTHESIS	$200
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	$60
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$80
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	$560
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$150
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$10
D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$710
D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$705
D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	$705
D6100	IMPLANT REMOVAL, BY REPORT	$250
D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$255
D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$315
D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	$265
D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$925
D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$925
D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$925

ADA	DESCRIPTION	MEMBER PAYS
IMPLANT SERVICES		
D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$925
D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$705
D6121	IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS	$665
D6122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	$665
D6123	IMPLANT SUPPT RETAINER FOR METAL FPD-TITANIUM/TITANIUM ALLOYS	$665
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$145
D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	$525
D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	$525
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	$575
D6195	ABUTMENT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$705
FIXED PROSTHODONTIC SERVICES		
D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	$250
D6210*	PONTIC - CAST HIGH NOBLE METAL	$125*
D6211	PONTIC - CAST PREDOM BASE METAL	$125*
D6212*	PONTIC - CAST NOBLE METAL	$125*
D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	$125*
D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	$125*
D6241	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	$125*
D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	$125*
D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$125*
D6245	PONTIC - PORCELAIN/CERAMIC	$215*
D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	$125*
D6251	PONTIC RESIN W/PREDOM BASE METAL	$125*
D6252*	PONTIC RESIN W/NOBLE METAL	$125*
D6253	PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$175
D6545	RETAINER - CASE METAL FOR RESIN FIXED PROSTHESIS	$250
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	$300*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	$85
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2 SURFACES	$145*
D6601	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$145*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	$115*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	$115*
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	$115*
D6605	RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES	$115*
D6606*	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$115*
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	$115*
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	$155*
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$155*
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	$115*
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	$115*
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	$150*
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	$150*
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$115*
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	$115*
D6624*	RETAINER INLAY - TITANIUM	$125*
D6634*	RETAINER ONLAY - TITANIUM	$125*
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$185*
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$125*
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$125*
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	$125*
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$215*
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$125*
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$125*
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$125*
D6753	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$125*
D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$125*
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$125*
D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	$125*
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$175*
D6784	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	$125*
D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$125*
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$125*
D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	$125*
D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	$125*
D6920	CONNECTOR BAR	$85
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$0
D6940	STRESS BREAKER	$110
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$140
ORAL SURGERY SERVICES		
D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	$0
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$0
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$15
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$25
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$50
D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	$75
D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	$90
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$0
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	$150
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$225
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	$50
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$85

ADA	DESCRIPTION	MEMBER PAYS
ORAL SURGERY SERVICES		
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	$85
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$0
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$0
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$20
D7288	BRUSH BIOPSY	$20
D7290	SURGICAL REPOSITIONING OF TEETH	$75
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$0
D7311	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	$0
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$0
D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	$0
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$215
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$670
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$70
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$110
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$100
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	$75
D7472	REMOVAL OF TORUS PALATINUS	$25
D7473	REMOVAL OF TORUS MANDIBULARIS	$25
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$25
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	$15
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	$15
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$70
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$190
D7530	REMOVAL OF FOREIGN BODY - SKIN SUBCUTANEOUS	$40
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	$0
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$15
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	$0
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	$0
D7963	FRENULOPLASTY	$0
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$25
D7971	EXCISION OF PERICORONAL GINGIVA	$20
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$40
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$5
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	$150
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$75
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$30
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$140
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$70
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$50
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$0
D9430	OV OBS - NO OTH SERVICES PERFORMED	$5
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$35
D9450	CASE PRSATION DTL & EXT TX PLANNING	$0
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9943	OCCLUSAL GUARD ADJUSTMENT	$0
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	$85
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	$85
D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH	$85
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$0
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$0
D9971	ODONTOPLASTY - PER TOOTH	$20
D9972	EXTERNAL BLEACHING - PER ARCH PERFORMED IN OFFICE	$125
D9975	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	$125
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME ENCOUNTER	$0
D9996	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW	$0
D9999	BROKEN APPOINTMENT	$10
ORTHODONTIC SERVICES		
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$1,895
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$1,895
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$1,895
D8660	PRE-ORTHODONTIC TREATMENT EXAM TO MONITOR GROWTH AND DEVELOPMENT	$250
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	$300
D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF TREATMENT	$150
D8999b	POST TREATMENT RECORDS	$150

ADA	DESCRIPTION	MEMBER PAYS

ADA	DESCRIPTION	MEMBER PAYS

[1]Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

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 Benefits:

1.	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS	Limited to 1 series of 4 films in any 6 month period
4.	DENTAL PROPHYLAXIS	Limited to 1 time per 6 months
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING	Limited to 4 quadrants per calendar year.
9.	PERIODONTAL MAINTENANCE	Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	REPLACEMENT OF COMPLETE DENTURES, 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 implant crowns, implant prostheses previously submitted for payment under the plan is limited to 1 time per tooth per 5 years from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable orthodontic appliances.
11.	REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (MAJOR RESTORATIVE SERVICES)	Replacement of complete dentures, and fixed and removable partial dentures or crowns 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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.	TEMPORARY CROWNS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	STAINLESS STEEL CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown -primary tooth, are limited to primary anterior teeth.
17.	ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS	Limited to repairs or adjustments performed more than 6 months after the initial insertion.
18.	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).
19.	ADJUNCTIVE PRE-DIAGNOSTIC TEST	That aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD 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 PCD must coordinate all Dental Services. • When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization... • If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notifi ed of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD 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 financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.
21.	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 Charges.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

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.	Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
4.	Any Dental Procedure not directly associated with dental disease.
5.	Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
6.	Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
7.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
8.	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.
9.	Replacement of complete dentures, fixed and removable partial dentures or crowns 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.
10.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
11.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
12.	Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
13.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
14.	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.
15.	Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
16.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
17.	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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
18.	Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
19.	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.
20.	Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
21.	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.
22.	Dental Services otherwise Covered under the Contract, but rendered after the date individual Coverage under the Contract terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Contract terminates.
23.	Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
24.	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.
25.	Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.
26.	Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Contract.

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:

27. Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

If you terminate coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. The following are not Covered orthodontic benefi ts:

- Extractions required for orthodontic purposes
- Surgical orthodontics or jaw repositioning
- Myofunctional therapy
- Cleft palate
- Micrognathia
- Macroglossia
- Hormonal imbalances
- Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of accident
- Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person

2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
3. 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.
4. 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.
5. One orthodontic benefi t under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefi t for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the fi rst 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefi t period.

