# UnitedHealthcare®

dental plan

## Direct Compensation (DC) Contributory CA240/covered dental services

CA D1094

| 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 - PROB FOCUS RPT | $0 |
| D0170 | RE-EVALUATION - LTD PROBLEM FOCUSED | $0 |
| D0171 | RE-EVALUATION – POST-OPERATIVE OFFICE VISIT | $0 |
| D0180 | COMP PERIODONTAL EVAL - NEW/EST PT | $0 |
| D0190 | SCREENING OF A PATIENT | $5 |
| D0191 | ASSESMENT OF A PATIENT | $5 |
| D0210 | INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES | $0 |
| D0220 | INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE | $0 |
| D0230 | INTRAORL PERIAPICAL EA 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 |
| D0290 | POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL SURVEY RADIOGRAPHIC IMAGE | $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 |
| 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 MICROORAGNISMS 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 TISS-GROSS EXAM-PREP & REPRT | $0 |
| D0473 | ACCESS TISS-GROSS/MICRO-PREP/REPRT | $0 |
| D0474 | ACSS TISS GR&MIC SURG MARG PREP/RPT | $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 |
| **PREVENTIVE SERVICES** | | |
| D1110 | PROPHYLAXIS - ADULT | $0 |

  

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|---|---|---|
| D1120 | PROPHYLAXIS - CHILD | $0 |
| D1206 | TOP FLUORIDE 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 |
| D1353 | SEALANT REPAIR – PER TOOTH | $0 |
| D1510 | SPACE MAINTAINER - FIXED-UNILATERAL | $0 |
| D1516 | SPACE MAINTAINER - FIXED-BILATERAL, MAXILLARY | $0 |
| D1517 | SPACE MAINTAINER - FIXED-BILATERAL, MANDIBULAR | $0 |
| D1520 | SPACE MAINTAINER - REMOVABLE-UNI | $0 |
| D1526 | SPACE MAINTAINER - REMOVABLE-BILATERAL, MAXILLARY | $0 |
| D1527 | SPACE MAINTAINER - REMOVABLE-BILATERAL, MANDIBULAR | |
| D1550 | RECEMENT OR RE-BOND SPACE MAINTAINER | $0 |
| D1555 | REMOVAL OF FIXED SPACE MAINTAINER | $0 |
| D1575 | DISTAL SHOE SPACE MAINTAINER – FIXED – UNILATERAL | $0 |
| **RESTORATIVE SERVICES** | | |
| D2140 | AMALGAM-ONE SURFACE PRIMARY/PERM | $5 |
| D2150 | AMALGAM-TWO SURFACES PRIMARY/PERM | $5 |
| D2160 | AMALGAM-3 SURFACES PRIMARY/PERM | $10 |
| D2161 | AMALGAM-FOUR/MORE SURF PRIM/PERM | $10 |
| D2330 | RESIN COMPOS - ONE SURFACE ANTERIOR | $5 |
| D2331 | RESIN COMPOS - 2 SURFACES ANTERIOR | $5 |
| D2332 | RESIN COMPOS - 3 SURFACES ANTERIOR | $10 |
| D2335 | RSN COMPOS-4/> SURF/W/INCISAL ANG | $10 |
| D2390 | RESIN COMPOS CROWN ANTERIOR | $20 |
| D2391 | RESIN COMPOS - 1 SURFACE POSTERIOR | $5 |
| D2392 | RESIN COMPOS - 2 SURFACES POSTERIOR | $10 |
| D2393 | RESIN COMPOS - 3 SURFACES POSTERIOR | $10 |
| D2394 | RESIN COMPOS - 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 SURF | $95 |
| D2610 | INLAY - PORCELN/CERAMIC - 1 SURFACE | $35 |
| D2620 | INLAY - PORCELN/CERAMIC - 2 SURF | $40 |
| D2630 | INLAY - PORCELN/CERAM - 3/MORE SURF | $45 |
| D2642 | ONLAY - PORCELN/CERAMIC - 2 SURF | $95 |
| D2643 | ONLAY - PORCELN/CERAMIC - 3 SURF | $95 |
| D2644 | ONLAY - PORCELN/CERAM - 4/MORE SURF | $95 |
| D2650 | INLAY-RSN COMPOS COMPOS/RSN-1 SURF | $30 |
| D2651 | INLAY-RSN COMPOS COMPOS/RSN-2 SURF | $35 |
| D2652 | INLAY-RSN COMPOS COMPOS/RSN-3/>SURF | $40 |
| D2662 | ONLAY-RSN COMPOS COMPOS/RSN-2 SURF | $30 |
| D2663 | ONLAY-RSN COMPOS COMPOS/RSN-3 SURF | $40 |
| D2664 | ONLAY-RSN COMPOS COMPOS/RSN-4/> | $45 |
| D2710 | CROWN RESINBASED COMPOSITE INDIRECT | $20 |
| D2712 | CROWN 3/4 RESNBASED COMPOS 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 - PORCELN FUSED HI NOBLE METL | $100 |
| D2751 | CROWN-PORCELN FUSD PREDOM BASE METL | $90 |

  

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|---|---|---|
| D2752* | CROWN - PORCELAIN FUSED NOBLE METAL | $100 |
| D2780* | CROWN - 3/4 CAST HIGH NOBLE METAL | $95 |
| D2781 | CROWN - 3/4 CAST PREDOM BASE METL | $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 METL | $90 |
| D2792* | CROWN - FULL CAST NOBLE METAL | $100 |
| D2794* | CROWN TITANIUM | $100 |
| D2910 | RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST | $5 |
| D2915 | RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFAB POST & CORE | $5 |
| D2920 | RECEMENT OR RE-BOND CROWN | $5 |
| D2921 | REATTACHMENT OF TOOTH FRAGMENT | $5 |
| D2929 | PREFABRICATED PORCELAIN CROWN- PRIMARY | $10 |
| D2930 | PRFABR STAINLESS STEEL CROWN-PRIM | $10 |
| D2931 | PRFABR STAINLESS STEEL CROWN-PERM | $10 |
| D2932 | PREFABRICATED RESIN CROWN | $10 |
| D2933 | PRFABR STNLSS STEEL CROWN RSN WNDOW | $10 |
| D2934 | PREFAB 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 RETN - PER TOOTH ADDITION REST | $5 |
| D2952 | POST & CORE ADD CROWN INDIRECT FAB | $25 |
| D2953 | EA ADD INDIRECT FAB POST SAME TOOTH | $5 |
| D2954 | PREFABR POST&CORE ADDITION CROWN | $10 |
| D2955 | POST REMOVAL | $20 |
| D2957 | EA ADD PREFABR POST - SAME TOOTH | $5 |
| D2960 | LABIAL VENEER (LAMINATE) - CHAIRSIDE | $20 |
| D2961 | LABIAL VENEER (RESIN LAMINATE) - LABORATORY | $40 |
| D2962 | LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY | $40 |
| D2971 | ADD PROC NEW CROWN XST PART DENTURE | $10 |
| D2975 | COPING | $70 |
| D2980 | CROWN REPAIR | $15 |
| D2990 | RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS | $10 |
| **ENDODONTIC SERVICES** | | |
| D3110 | PULP CAP - DIRECT | $0 |
| D3120 | PULP CAP - INDIRECT | $0 |
| D3220 | TX PULPOT-CORONL DENTNOCEMENTL JUNC | $0 |
| D3221 | PULPAL DEBRID PRIMARY&PERM TEETH | $5 |
| D3222 | PARTIAL PULPOTOMY | $0 |
| D3230 | PULPAL THERAPY - ANT PRIMARY TOOTH | $0 |
| D3240 | PULPAL THERAPY - POST 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 | APEXIFICAT/RECALCIFICAT - INIT VST | $5 |
| D3352 | APEXIFICAT/RECALCIFICAT-INTERIM | $5 |
| D3353 | APEXIFICAT/RECALCIFICAT-FINAL VISIT | $10 |
| D3355 | PULPAL REGENERATION - INITIAL VISIT | $5 |
| D3356 | PULPAL REGENERATION -INTERIM MEDICAMENT REPLACEMENT | $5 |
| D3357 | PULPAL REGENERATION - COMPLETION OF TREATMENT | $10 |

  

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|---|---|---|
| D3410 | APICOECTOMY SURG - ANT | $15 |
| D3421 | APICOECTOMY SURG-BICUSPID | $20 |
| D3425 | APICOECTOMY SURG - MOLAR | $30 |
| D3426 | APICOECTOMY SURGERY | $10 |
| D3427 | PERIRADICULAR SURGERY WITHOUT APICOECTOMY | $13 |
| D3430 | RETROGRADE FILLING - PER ROOT | $10 |
| D3450 | ROOT AMPUTATION - PER ROOT | $12 |
| D3460 | ENDODONTIC ENDOSSEOUS IMPLANT | $1,950 |
| D3910 | SURG PROC ISOLAT TOOTH W/RUBBER DAM | $5 |
| D3920 | HEMISECTION NOT INCL RC THERAPY | $5 |
| D3950 | CANAL PREP&FIT PREFORMED DOWEL/POST | $5 |
| **PERIODONTIC SERVICES** | | |
| D4210 | GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD | $10 |
| D4211 | GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD | $5 |
| D4212 | GINGIVECT/PLSTY WITH REST PROC/TOOTH | $0 |
| 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 REPLCMT GRAFT - 1 SITE QUAD | $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 |
| D4278 | FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH | $5 |
| D4320 | PROVISIONAL SPLINTING - INTRACORONAL | $10 |
| D4321 | PROVISIONAL SPLINTING - EXTRACORONAL | $5 |
| D4341 | PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD | $5 |
| D4342 | PRDONTAL 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 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 - PER QUADRANT | $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 | MAX PARTIAL DENTURE - RESIN BASE | $40 |
| D5212 | MAND PARTIAL DENTUR - RESIN BASE | $40 |
| D5213 | MAX PART DENTUR-CAST METL W/RSN | $140 |
| D5214 | MAND PART DENTUR- CAST METL W/RSN | $140 |
| D5221 | IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | $30 |
| D5222 | IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | $30 |
| D5223 | IMMEDIATE MAXILLARY PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | $30 |
| D5224 | IMMEDIATE MANDIBULAR PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | $30 |

  

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|---|---|---|
| D5225 | MAXILLARY PARTIAL DENTURE FLEX BASE | $40 |
| D5226 | MANDIBULAR PART DENTURE FLEX BASE | $40 |
| D5282 | REMV UNI PART DENTUR-1 PC CAST METL - MAXILLARY | $20 |
| D5283 | REMV UNI PART DENTUR-1 PC CAST METL - MANDIBULAR | $20 |
| D5410 | ADJUST COMPLETE DENTURE - MAXILLARY | $5 |
| D5411 | ADJUST COMPLETE DENTUR - 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 | REPL MISS/BROKEN TEETH-CMPL DENTUR | $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 | REPL ALL TEETH&ACRYLC FRMEWRK MAX | $45 |
| D5671 | REPL ALL TEETH&ACRYLC FRMEWRK MAND | $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 |
| D5730 | RELINE CMPL MAXIL DENTURE CHAIRSIDE | $25 |
| D5731 | RELINE CMPL MAND DENTURE CHAIRSIDE | $25 |
| D5740 | RELINE MAXIL PART DENTURE CHAIRSIDE | $20 |
| D5741 | RELINE MAND PART DENTURE CHAIRSIDE | $20 |
| D5750 | RELINE CMPL MAXIL DENTURE LAB | $30 |
| D5751 | RELINE CMPL MAND DENTRUE LABORATORY | $30 |
| D5760 | RELINE MAXIL PART DENTURE LAB | $30 |
| D5761 | RELINE MAND PART DENTURE LABORATORY | $30 |
| 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 MENTAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE, PER ARCH | $40 |
| **IMPLANT SERVICES** | | |
| D6010 | SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT | $1,950 |
| D6011 | SECOND STAGE IMPLANT SURGERY | $1,950 |
| D6013 | SURGICAL PLACEMENT OF A MINI-IMPLANT | $1,950 |
| D6052 | SEMI-PRECISION ATTACHMENT ABUTMENT | $368 |
| 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 | $946 |

  

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|---|---|---|
| | METAL) | |
| 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 PORCELAIN FUSED TO METAL CROWN | $1,083 |
| D6067* | IMPLANT SUPPORTED METAL CROWN | $962 |
| D6068 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD | $1,026 |
| 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 PORCELAIN FUSED TO METAL FPD | $992 |
| D6077* | IMPLANT SUPPORTED RETAINER FOR CASE METAL FPD | $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 |
| D6090 | REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT | $135 |
| D6091 | REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT(MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS | $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 | $810 |
| D6095 | REPAIR IMPLANT ABUTMENT, BY REPORT | $55 |
| D6096 | REMOVE BROKEN IMPLANT RETAINING SCREW | $20 |
| D6100 | IMPLANT REMOVAL, BY REPORT | $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 |
| 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 |
| D6190 | RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT | $265 |
| D6194 | ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM | $835 |
| **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 |

  

| ADA | DESCRIPTION | MEMBER PAYS |
|---|---|---|
| D6214* | PONTIC TITANIUM | $80 |
| D6240* | PONTIC-PORCELN FUSED HI NOBLE METL | $80 |
| D6241 | PONTIC-PORCLN FUSD PREDOM BASE METL | $75 |
| D6242* | PONTIC - PORCELN FUSED NOBLE METAL | $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 | PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION | $25 |
| D6545 | RETAINER- CASE MTL FOR RESIN FXD PROS | $10 |
| D6548 | RET-PORC/CER FOR RESIN BONDED FIXED PROS | $10 |
| D6549 | RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS | $10 |
| D6600 | RETAINER INLAY-PORCELAIN/CERAMIC 2 SURFACES | $40 |
| D6601 | RETAINER INLAY - PORCELN/CERAMIC 3/MORE SURF | $45 |
| D6602* | RETAINER INLAY - CAST HI NOBLE METAL 2 SURF | $40 |
| D6603* | RETAINER INLAY-CAST HI NOBLE METL 3/> SURF | $45 |
| D6604 | RETAINER INLAY-CAST PREDOM BASE METL 2 SURF | $40 |
| D6605 | RETAINER INLAY-CAST PREDOM BASE METL 3/>SURF | $45 |
| D6606* | RETAINER INLAY - CAST NOBLE METAL 2 SURFACES | $40 |
| D6607* | RETAINER INLAY - CAST NOBLE METL 3/MORE SURF | $45 |
| D6608 | RETAINER ONLAY - PORCELN/CERAMIC 2 SURFACES | $45 |
| D6609 | RETAINER ONLAY - PORCELN/CERAMIC 3/MORE SURF | $50 |
| D6610* | RETAINER ONLAY - CAST HI NOBLE METAL 2 SURF | $55 |
| D6611* | RETAINER ONLAY-CAST HI NOBLE METL 3/> SURF | $60 |
| D6612 | RETAINER ONLAY-CAST PREDOM BASE METL 2 SURF | $50 |
| D6613 | RETAINER ONLAY-CAST PREDOM BASE METL 3/>SURF | $55 |
| D6614* | RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES | $50 |
| D6615* | RETAINER ONLAY - CAST NOBLE METL 3/MORE SURF | $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 |
| 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 |
| 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 | $100 |
| D6920 | CONNECTOR BAR | $70 |
| 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 CORONL RMNNTS DECIDUOUS 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 |

  

| ADA | DESCRIPTION | MEMBER PAYS |
|---|---|---|
| D7240 | REMOVAL IMPACTED TOOTH - CMPL BONY | $15 |
| D7241 | REMV IMP TOOTH-CMPL BNY W/SURG COMP | $25 |
| D7250 | REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) | $5 |
| D7251 | CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL | $5 |
| D7261 | PRIMARY CLOSURE OF A SINUS PERFORATION | $10 |
| D7270 | TOOTH REIMPL&/STBL ACC DISPLCD | $10 |
| D7280 | SURGICAL ACCESS AN UNERUPTED TOOTH | $10 |
| D7282 | MOBILZ ERUPT/MALPSTN TOOTH AID ERUP | $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 | ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH | $5 |
| D7320 | ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC | $10 |
| D7321 | ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH | $5 |
| D7340 | VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) | $20 |
| 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 | SURGICAL RDUC OSSEOUS TUBEROSITY | $25 |
| D7510 | I&D ABSCESS-INTRAORAL SOFT TISS | $5 |
| D7511 | I & D ABSC INTRAORAL SOFT TISS COMP | $5 |
| D7520 | I & D OF ABSCESS EXTRAORAL SOFT TISSUE | $10 |
| D7521 | I & D OF ABSCESS EXTRAORAL COMPLICATED | $10 |
| D7530 | REMO OF FORREIGN BODY - SKIN SUBCUTANEOUS | $5 |
| D7910 | SUTURE RECENT SMALL WOUNDS UP 5 CM | $0 |
| D7960 | FRENULECTOMY SEPARATE PROCEDURE | $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 | PALLIATVE TX DENTAL PAIN-MINOR PROC | $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 | $5 |
| 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 | $5 |
| D9243 | INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT | $5 |

  

| ADA | DESCRIPTION | MEMBER PAYS |
|---|---|---|
| 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 APPLIACNE, FULL ARCH | $15 |
| D9946 | OCCLUSAL GUARD – HARD APPLIANCE, PARTIAL ARCH | $15 |
| D9951 | OCCLUSAL ADJUSTMENT - LIMITED | $5 |
| D9952 | OCCLUSAL ADJUSTMENT - COMPLETE | $5 |
| D9971 | ODONTOPLASTY | $0 |
| D9972 | EXTERNAL BLEACHING - PER ARCH PERFORMED IN OFFICE | $125 |
| D9995 | TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW | $0 |
| D9996 | BROKEN APPOINTMENT | $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 |
| **Fixed Prosthedontics** | | |
| D5992 | ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT | $5 |

*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. 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 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 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.<br>• In order for specialty services to be Covered by this plan, the following referral process must be followed:<br>• A Covered Person's Participating Dentist must coordinate all Dental Services.<br>• When the care of a Network Specialist Dentist is required, the Covered Person's Participating Dentist must contact us and request authorization.<br>• 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.<br>• 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.<br>• 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. |

**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. |

  

**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:**

| | |
|---|---|
| 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. |
| 22. | Orthodontic Exclusions & Limitations<br>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.<br>Orthodontic Exclusions:<br>a) Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person<br>b) Treatment in progress prior to the effective date of this coverage<br>c) Extractions required for orthodontic purposes<br>d) Surgical orthodontics or jaw repositioning<br>e) Myofunctional therapy<br>f) Cleft palate<br>g) Micrognathia<br>h) Macroglossia<br>i) Hormonal imbalances<br>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<br>k) Palatal expansion appliances<br>l) Services performed by outside laboratories<br>Orthodontic Limitations:<br>1. If a treatment plan is for less than 24 months, then a prorated portion of the full copayment shall apply.<br>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.<br>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.<br>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. |

  