# UnitedHealthcare®

## Select Managed Care Direct Compensation Contributory CA210/covered dental services

Dental Plan
CA D1061

| ADA | DESCRIPTION | MEMBER'S COPAYMENT |
|---|---|---|
| **DIAGNOSTIC SERVICES** | | |
| D0120 | PERIODIC ORAL EVAL ESTABLISHED PATIENT | $0 |
| D0140 | LIMITED ORAL EVAL - PROBLEM FOCUSED | $0 |
| D0145 | ORAL EVAL PATIENT <3 AND COUNSEL WITH PRIMARY CARE GIVER | $0 |
| D0150 | COMPREHENSIVE ORAL EVAL - NEW/ESTABLISHED PATIENT | $0 |
| D0160 | DETAILED & EXTENSIVE ORAL EVAL - PROBLEM FOCUSED REPRT | $0 |
| D0170 | RE-EVAL - LIMITED PROBLEM FOCUSED | $0 |
| D0180 | COMPREHENSIVE PERIODONTAL EVAL - NEW/ESTABLISHED PATIENT | $0 |
| D0190 | SCREENING OF A PATIENT | $5 |
| D0191 | ASSESSMENT OF A PATIENT | $5 |
| D0210 | INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES | $0 |
| D0220 | INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE | $0 |
| D0230 | INTRAORAL - PERIAPICAL EACH ADDL RADIOGRAPHIC IMAGE | $0 |
| D0240 | INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE | $0 |
| D0250 | EXTRAORAL - FIRST RADIOGRAPHIC IMAGE | $0 |
| D0260 | EXTRAORAL - EACH ADDITIONAL 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 | POST-ANTERIOR LATERAL SKULL & FACIAL RADIOGRAPHIC IMAGE | $0 |
| D0330 | PANORAMIC RADIOGRAPHIC IMAGE | $0 |
| D0340 | CEPHALOMETRIC RADIOGRAPH IMAGE | $30 |
| D0391 | INTERPRETATION OF DIAGNOSTIC IMAGE | $10 |
| D0415 | COLLECT MICROORGANISMS CULTURE & SENSITIVITY | $0 |
| D0416 | VIRAL CULTURE | $0 |
| D0417 | COLLECTION & PREPARATION OF SALIVA SAMPLE | $0 |
| D0418 | ANALYSIS OF SALIVA SAMPLE | $0 |
| D0421 | GENETIC TEST FOR SUSCEPTIBILITY TO ORAL DISEASES | $0 |
| D0425 | CARIES SUSCEPTIBILITY TESTS | $0 |
| D0431 | ADJUNCTIVE PREDIAGNOSTIC TEST | $0 |
| D0460 | PULP VITALITY TESTS | $0 |
| D0470 | DIAGNOSTIC CASTS | $0 |
| D0472 | ACCESSION OF TISSUE-GROSS EXAM, PREP & REPRT | $0 |
| D0473 | ACCESSION OF TISSUE-GROSS/MICRO EXAM PREP & REPRT | $0 |
| D0474 | ACCESSION OF TISSUE-MICRO GROSS/MICRO EXAM, INCLD ASSESS MARGIN FOR DISEASE, PREP & REPRT | $0 |
| D0601 | CARIES RISK ASSESS & DOCUMENT W/FIND LOW RISK | $0 |
| D0602 | CARIES RISK ASSESS & DOCUMENT W/FIND MODERATE RISK | $0 |
| D0603 | CARIES RISK ASSESS & DOCUMENT W/FIND HIGH RISK | $0 |
| **PREVENTIVE SERVICES** | | |
| D1110 | PROPHYLAXIS - ADULT | $0 |
| D1120 | PROPHYLAXIS - CHILD | $0 |
| D1206 | TOPICAL APPLICATION OF FLUORIDE VARNISH | $0 |
| D1208 | TOPICAL APPLICATION OF FLUORIDE | $0 |
| D1310 | NUTRITIONAL COUNSELING CONTROL DENTAL DISEASE | $0 |
| D1320 | TOBACCO COUNSELING CONTROL & PREV ORAL DISEASE | $0 |
| D1330 | ORAL HYGIENE INSTRUCTIONS | $0 |
| D1351 | SEALANT - PER TOOTH | $0 |
| D1352 | PREV RESIN RESTORATION MOD HIGH CARIES RISK PATIENT | $0 |
| D1510 | SPACE MAINTAINER - FIXED-UNILATERAL | $0 |
| D1515 | SPACE MAINTAINER - FIXED-BILATERAL | $0 |
| D1520 | SPACE MAINTAINER - REMOVABLE-UNILATERAL | $0 |
| D1525 | SPACE MAINTAINER - REMOVABLE-BILATERAL | $0 |
| D1550 | RECEMENTATION OF SPACE MAINTAINER | $0 |
| D1555 | REMOVAL OF FIXED SPACE MAINTAINER | $0 |
| **RESTORATIVE SERVICES** | | |
| D2140 | AMALGAM - 1 SURFACE PRIMARY/PERMANENT | $30 |
| D2150 | AMALGAM- 2 SURFACES PRIMARY/PERMANENT | $45 |
| D2160 | AMALGAM - 3 SURFACES PRIMARY/PERMANENT | $55 |
| D2161 | AMALGAM - 4/> SURFACES PRIMARY/PERMANENT | $55 |
| D2330 | RESIN-BASED COMPOSITE - 1 SURFACE, ANTERIOR | $30 |
| D2331 | RESIN COMPOSITE - 2 SURFACES, ANTERIOR | $45 |
| D2332 | RESIN COMPOSITE - 3 SURFACES, ANTERIOR | $60 |
| D2335 | RESIN COMPOSITE - 4/> SURFACES/W/INCISAL ANG | $60 |
| D2390 | RESIN COMPOSITE CROWN ANTERIOR | $55 |
| D2391 | RESIN COMPOSITE - 1 SURFACE POSTERIOR | $45 |
| D2392 | RESIN COMPOSITE - 2 SURFACES POSTERIOR | $65 |
| D2393 | RESIN COMPOSITE - 3 SURFACES POSTERIOR | $85 |
| D2394 | RESIN COMPOSITE- 4/MORE SURFACES POST | $85 |
| D2510 | INLAY - METALLIC - 1 SURFACE | $285 |
| D2520 | INLAY - METALLIC - 2 SURFACES | $285 |
| D2530 | INLAY - METALLIC - 3/> SURFACES | $285 |
| D2542 | ONLAY - METALLIC - 2 SURFACES | $285 |
| D2543 | ONLAY - METALLIC - 3 SURFACES | $285 |
| D2544 | ONLAY - METALLIC 4/> SURFACES | $285 |
| D2610 | INLAY - PORCELAIN/CERAMIC - 1 SURFACE | $100 |
| D2620 | INLAY - PORCELAIN/CERAMIC - 2 SURFACES | $120 |
| D2630 | INLAY - PORCELAIN/CERAMIC - 3/> SURFACES | $140 |
| D2642 | ONLAY - PORCELAIN/CERAMIC - 2 SURFACES | $285 |
| D2643 | ONLAY - PORCELAIN/CERAMIC - 3 SURFACES | $285 |
| D2644 | ONLAY - PORCELAIN/CERAMIC - 4/> SURFACES | $285 |
| D2650 | INLAY - RESIN BASED COMPOSITE -1 SURFACE | $85 |
| D2651 | INLAY - RESIN BASED COMPOSITE - 2 SURFACES | $100 |
| D2652 | INLAY - RESIN BASED COMPOSITE - 3/> SURFACES | $115 |
| D2662 | ONLAY - RESIN BASED COMPOSITE -2 SURFACES | $90 |
| D2663 | ONLAY - RESIN BASED COMPOSITE -3 SURFACES | $120 |
| D2664 | ONLAY - RESIN BASED COMPOSITE - 4/> SURFACES | $140 |
| D2710 | CROWN - RESIN BASED COMPOSITE INDIRECT | $55 |
| D2712 | CROWN - 3/4 RESIN BASED COMPOSITE INDIRECT | $55 |
| D2720 | CROWN - RESIN WITH HIGH NOBLE METAL* | $115 |
| D2721 | CROWN - RESIN WITH PREDOMINANTLY BASE METAL | $85 |
| D2722 | CROWN - RESIN WITH NOBLE METAL* | $95 |
| D2740 | CROWN - PORCELAIN/CERAMIC SUBSTRATE | $295 |
| D2750 | CROWN - PORCELAIN FUSED HIGH NOBLE METAL* | $295 |
| D2751 | CROWN - PORCELAIN FUSED PREDOMINANTLY BASE METAL | $275 |
| D2752 | CROWN - PORCELAIN FUSED NOBLE METAL* | $295 |
| D2780 | CROWN - 3/4 CAST HIGH NOBLE METAL* | $285 |
| D2781 | CROWN - 3/4 CAST PREDOMINANTLY BASE METAL | $270 |
| D2782 | CROWN - 3/4 CAST NOBLE METAL* | $285 |

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|---|---|---|
| D2783 | CROWN - 3/4 PORCELAIN/CERAMIC | $285 |
| D2790 | CROWN - FULL CAST HIGH NOBLE METAL* | $295 |
| D2791 | CROWN - FULL CAST PREDOMINANTLY BASE METAL | $275 |
| D2792 | CROWN - FULL CAST NOBLE METAL* | $295 |
| D2794 | CROWN TITANIUM* | $295 |
| D2910 | RECEMENT INLAY, ONLAY/PARTIAL COVERAGE RESTOR | $10 |
| D2915 | RECEMENT CAST/PREFABRICATED POST & CORE | $10 |
| D2920 | RECEMENT CROWN | $10 |
| D2921 | REATTACH TOOTH FRAGMENT, INCISAL EDGE OR CUSP | $15 |
| D2929 | PREFABRIC PORCELAIN/CERAMIC CROWN-PRIMARY-TOOTH | $30 |
| D2930 | PREFARBICATED STAINLESS STEEL CROWN - PRIMARY | $25 |
| D2931 | PREFABRICATED STAINLESS STEEL CROWN - PERMANENT | $35 |
| D2932 | PREFABRICATED RESIN CROWN | $30 |
| D2933 | PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW | $25 |
| D2934 | PREFABRIC ESTHTC COAT STNLS STL CRWN-PRIMARY TOOTH | $25 |
| D2940 | PROTECTIVE RESTORATION | $10 |
| D2941 | INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION | $10 |
| D2950 | CORE BUILD-UP, INCLUDING ANY PINS | $15 |
| D2951 | PIN RETENTION - PER TOOTH ADDITION RESTORATION | $10 |
| D2952 | POST & CORE ADDITION CROWN INDIRECTLY FABRICATED | $70 |
| D2953 | EACH ADDL INDIRECTLY FABRICATED POST - SAME TOOTH | $20 |
| D2954 | PREFABRICATED POST & CORE ADDITION CROWN | $30 |
| D2955 | POST REMOVAL | $60 |
| D2957 | EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH | $10 |
| D2960 | LABIAL VENEER (RESIN BASED) - CHAIRSIDE | $60 |
| D2961 | LABIAL VENEER (RESIN BASED) - LABORATORY | $115 |
| D2962 | LABIAL VENEER (PORCELAIN LAMINATE) | $115 |
| D2970 | TEMPORARY CROWN | $35 |
| D2971 | ADDL PROCEDURE NEW CROWN EXIST PARTIAL DENTURE | $35 |
| D2975 | COPING | $215 |
| D2980 | CROWN REPAIR | $45 |
| D2990 | RESIN INFILTRATION INCIPIENT SMTH SURFACE LESIONS | $15 |
| **ENDODONTIC SERVICES** | | |
| D3110 | PULP CAP - DIRECT | $15 |
| D3120 | PULP CAP - INDIRECT | $5 |
| D3220 | THERAPEUTIC PULPOTOMY | $15 |
| D3221 | PULPAL DEBRIDEMENT PRIMARY & PERMANENT TEETH | $20 |
| D3222 | PARTIAL PULPTOMY FOR APEXOGENESIS PERMANENT TOOTH | $15 |
| D3230 | PULPAL THERAPY - ANTERIOR PRIMARY TOOTH | $15 |
| D3240 | PULPAL THERAPY - POSTERIOR PRIMARY TOOTH | $15 |
| D3310 | ENDODONTIC THERAPY, ANTERIOR TOOTH | $120 |
| D3320 | ENDODONTIC THERAPY, BICUSPID TOOTH | $220 |
| D3330 | ENDODONTIC THERAPY, MOLAR | $350 |
| D3331 | TREATMENT ROOT CANAL OBSTRUCTION; NON-SURG ACCESS | $20 |
| D3332 | INCOMPLETED ENDODONTIC THERAPY | $15 |
| D3333 | INTERNAL ROOT REPAIR PERFORATION DEFECTS | $45 |
| D3346 | RETREATMENT PREV ROOT CANAL THERAPY - ANTERIOR | $120 |
| D3347 | RETREATMENT PREV ROOT CANAL THERAPY - BICUSPID | $160 |
| D3348 | RETREATMENT PREV ROOT CANAL THERAPY - MOLAR | $280 |
| D3351 | APEXIFICATION/RECALCIFICATION INITIAL VISIT | $35 |
| D3352 | APEXIFICATION/RECALCIFICATION INTERIM MEDICATION REPLACEMENT | $30 |
| D3353 | APEXIFICATION/RECALCIFICATION - FINAL VISIT | $60 |
| D3355 | PULPAL REGENERATION - INITIAL VISIT | $35 |
| D3356 | PULPAL REGENERATION -INTERIM MEDICAMENT REPLACEMNT | $30 |
| D3357 | PULPAL REGENERATION - COMPLETION OF TREATMENT | $60 |
| D3410 | APICOECTOMY - ANTERIOR | $105 |
| D3421 | APICOECTOMY - BICUSPID | $160 |
| D3425 | APICOECTOMY - MOLAR | $240 |
| D3426 | APICOECTOMY - EACH ADDITIONAL ROOT | $80 |
| D3427 | PERIRADICULAR SURGERY WITHOUT APICOECTOMY | $80 |
| D3430 | RETROGRADE FILLING - PER ROOT | $75 |
| D3450 | ROOT AMPUTATION - PER ROOT | $60 |
| D3460 | ENDODONTIC ENDOSSEOUS IMPLANT | $1950 |
| D3910 | SURGICAL PROCED ISOLATION TOOTH W/RUBBER DAM | $30 |
| D3920 | HEMISECTION NOT INCLUDIING ROOT CANAL THERAPY | $45 |
| D3950 | CANAL PREPARATION & FIT PREFORMED DOWEL/POST | $40 |
| **PERIODONTIC SERVICES** | | |
| D4210 | GINGIVECTOMY/GINGIVOPLASTY 4/> CNTIG TEETH QUAD | $70 |
| D4211 | GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD | $25 |
| D4212 | GINGIVECTOMY/GINGIVOPLASTY ALLOW ACCESS RESTOR PROC, PER TOOTH | $10 |
| D4240 | GINGIVAL FLAP - 4/>CNTIG/BOUND TEETH QUAD | $70 |
| D4241 | GINGIVAL FLAP - 1-3 CNTIG/BOUND TEETH QUAD | $45 |
| D4245 | APICALLY POSITIONED FLAP | $80 |
| D4249 | CLINICAL CROWN LENGTHENING - HARD TISSUE | $75 |
| D4260 | OSSEOUS SURGERY - 4/> CONTIGUOUS TEETH QUAD | $235 |
| D4261 | OSSEOUS SURGERY - 1-3 CONTIGUOUS TEETH QUAD | $150 |
| D4263 | BONE REPLACEMENT GRAFT - 1 SITE QUAD | $120 |
| D4270 | PEDICLE SOFT TISSUE GRAFT PROCEDURE | $70 |
| D4274 | DISTAL OR PROXIMAL WEDGE PROCEDURE - SEPARATE PROCEDURE | $70 |
| D4277 | FREE SOFT TISSUE GRAFT PROCEDURE (INCLD DONOR SITE SURGERY), FIRST TOOTH | $95 |
| D4278 | FREE SOFT TISSUE GRAFT PROCEDURE (INCLD DONOR SITE SURGERY), EACH ADDL; CONTIGUOUS TOOTH | $45 |
| D4320 | PROVISONAL SPLINTING - INTRACORONAL | $75 |
| D4321 | PROVISONAL SPLINTING - EXTRACORONAL | $60 |
| D4341 | PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD | $65 |
| D4342 | PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH | $40 |
| D4355 | FULL MOUTH DEBRIDEMENT COMP EVAL & DIAGNOSIS | $40 |
| D4381 | LOCAL DELIVERY ANTIMICROBIAL AGENT PER TOOTH | $20 |
| D4910 | PERIODONTAL MAINTENANCE | $35 |
| D4920 | UNSCHEDULED DRESSING CHANGE | $15 |
| D4921 | GINGIVAL IRRIGATION - PER QUADRANT | $0 |
| **REMOVABLE PROSTHODONTICS SERVICES** | | |
| D5110 | COMPLETE DENTURE - MAXILLARY | $420 |
| D5120 | COMPLETE DENTURE - MANDIBULAR | $420 |
| D5130 | IMMEDIATE DENTURE - MAXILLARY | $420 |
| D5140 | IMMEDIATE DENTURE - MANDIBULAR | $420 |
| D5211 | MAXILLARY PARTIAL DENTURE - RESIN BASE | $120 |
| D5212 | MANDIBULAR PARTIAL DENTURE - RESIN BASE | $120 |
| D5213 | MAXILLARY PARTIAL DENTURE -CAST METAL W/RESIN | $425 |
| D5214 | MANDIBULAR PARTIAL DENTURE - CAST METAL W/RESIN | $425 |
| D5225 | MAXILLARY PARTIAL DENTURE FLEX BASE | $125 |
| D5226 | MANDIBULAR PARTIAL DENTURE FLEX BASE | $125 |
| D5281 | REMOVAL UNILATERAL PARTIAL DENTURE -1 PC CAST METAL | $65 |
| D5410 | ADJUST COMPLETE DENTURE - MAXILLARY | $10 |
| D5411 | ADJUST COMPLETE DENTURE - MANDIBULAR | $10 |
| D5421 | ADJUST PARTIAL DENTURE - MAXILLARY | $10 |
| D5422 | ADJUST PARTIAL DENTURE - MANDIBULAR | $10 |



  

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|---|---|---|
| D5510 | REPAIR BROKEN COMPLETE DENTURE BASE | $35 |
| D5520 | REPLACE MISSING/BROKEN TEETH-COMPLETE DENTURE | $20 |
| D5610 | REPAIR RESIN DENTURE BASE | $35 |
| D5620 | REPAIR CAST FRAMEWORK | $70 |
| D5630 | REPAIR OR REPLACE BROKEN CLASP | $70 |
| D5640 | REPLACE BROKEN TEETH - PER TOOTH | $35 |
| D5650 | ADD TOOTH EXISTING PARTIAL DENTURE | $35 |
| D5660 | ADD CLASP EXISTING PARTIAL DENTURE | $60 |
| D5670 | REPLACE ALL TEETH & ACRYLIC FRAMEWORK MAXILLARY | $140 |
| D5671 | REPLACE ALL TEETH & ACRYLIC FRAMEWORK MANDIBULAR | $140 |
| D5710 | REBASE COMPLETE MAXILLARY DENTURE | $120 |
| D5711 | REBASE COMPLETE MANDIBULAR DENTURE | $120 |
| D5720 | REBASE MAXILLARY PARTIAL DENTURE | $95 |
| D5721 | REBASE MANDIBULAR PARTIAL DENTURE | $95 |
| D5730 | RELINE COMPLETE MAXILLARY DENTURE CHAIRSIDE | $70 |
| D5731 | RELINE COMPLETE MANDIBULAR DENTURE CHAIRSIDE | $70 |
| D5740 | RELINE MAXILLARY PARTIAL DENTURE CHAIRSIDE | $55 |
| D5741 | RELINE MANDIBULAR PARTIAL DENTURE CHAIRSIDE | $55 |
| D5750 | RELINE COMPLETE MAXILLARY DENTURE LABORATORY | $90 |
| D5751 | RELINE COMPLETE MANDIBULAR DENTURE LABORATORY | $90 |
| D5760 | RELINE MAXILLARY PARTIAL DENTURE LABORATORY | $90 |
| D5761 | RELINE MANDIBULAR PARTIAL DENTURE LABORATORY | $90 |
| D5810 | INTERIM COMPLETE DENTURE MAXILLARY | $120 |
| D5811 | INTERIM COMPLETE DENTURE MANDIBULAR | $120 |
| D5820 | INTERIM PARTIAL DENTURE MAXILLARY | $90 |
| D5821 | INTERIM PARTIAL DENTURE MANDIBULAR | $90 |
| D5850 | TISSUE CONDITIONING MAXILLARY | $20 |
| D5851 | TISSUE CONDITIONING MANDIBULAR | $20 |
| D5863 | OVERDENTURE - COMPLETE MAXILLARY | $420 |
| D5864 | OVERDENTURE - PARTIAL MAXILLARY | $420 |
| D5865 | OVERDENTURE - COMPLETE MANDIBULAR | $425 |
| D5866 | OVERDENTURE - PARTIAL MANDIBULAR | $425 |
| D5992 | ADJUST MAXILLOFACIAL PROSTH APPLIANCE, BY REPORT | $10 |
| **FIXED PROSTHODONTICS SERVICES** | | |
| D6205 | PONTIC - INDIRECT RESIN BASED COMPOSITE | $60 |
| D6210 | PONTIC - CAST HIGH NOBLE METAL* | $240 |
| D6211 | PONTIC - CAST PREDOMINANTLY BASE METAL | $230 |
| D6212 | PONTIC - CAST NOBLE METAL* | $240 |
| D6214 | PONTIC - TITANIUM* | $240 |
| D6240 | PONTIC - PORCELAIN FUSED HIGH NOBLE METAL* | $240 |
| D6241 | PONTIC - PORCELAIN FUSED PREDOMINANTLY BASE METAL | $230 |
| D6242 | PONTIC - PORCELAIN FUSED NOBLE METAL* | $240 |
| D6245 | PONTIC - PORCELAIN/CERAMIC | $285 |
| D6250 | PONTIC - RESIN W/HIGH NOBLE METAL* | $70 |
| D6251 | PONTIC - RESIN W/PREDOMINANTLY BASE METAL | $40 |
| D6252 | PONTIC - RESIN W/NOBLE METAL* | $50 |
| D6253 | PROVISIONAL PONTIC | $75 |
| D6545 | RETAINER-CAST METAL, RESIN, BOND FIXED PROSTHETIC | $35 |
| D6548 | RETAINER-PORCELAIN/CERAMIC, RESN BOND FIXED PROSTHETIC | $35 |
| D6600 | INLAY - PORCELAIN/CERAMIC 2 SURFACES | $120 |
| D6601 | INLAY - PORCELAIN/CERAMIC 3/> SURFACES | $140 |
| D6602 | INLAY - CAST HIGH NOBLE METAL 2 SURFACES* | $120 |
| D6603 | INLAY - CAST HIGH NOBLE METAL 3/> SURFACES* | $140 |
| D6604 | INLAY - CAST PREDOMINANTLY BASE METAL 2 SURFACES | $120 |
| D6605 | INLAY - CAST PREDOMINANTLY BASE METAL 3/>SURFACES | $140 |
| D6606 | INLAY - CAST NOBLE METAL 2 SURFACES* | $120 |
| D6607 | INLAY - CAST NOBLE METAL 3/> SURFACES* | $140 |
| D6608 | ONLAY - PORCELAIN/CERAMIC 2 SURFACES | $140 |
| D6609 | ONLAY - PORCELAIN/CERAMIC 3/> SURFACES | $145 |
| D6610 | ONLAY - CAST HIGH NOBLE METAL 2 SURFACES* | $160 |
| D6611 | ONLAY-CAST HIGH NOBLE METAL 3/> SURFACES* | $175 |
| D6612 | ONLAY - CAST PREDOMINANTLY BASE METAL 2 SURFACES | $145 |
| D6613 | ONLAY - CAST PREDOMINANTLY BASE METAL 3/>SURFACES | $160 |
| D6614 | ONLAY - CAST NOBLE METAL 2 SURFACES* | $145 |
| D6615 | ONLAY - CAST NOBLE METAL 3/> SURFACES* | $155 |
| D6624 | INLAY TITANIUM* | $140 |
| D6634 | ONLAY TITANIUM* | $230 |
| D6710 | CROWN/INDIRECT RESIN BASED COMPOSITION | $60 |
| D6720 | CROWN - RESIN WITH HIGH NOBLE METAL* | $115 |
| D6721 | CROWN - RESIN PREDOMINANTLY BASE METAL | $85 |
| D6722 | CROWN - RESIN WITH NOBLE METAL* | $95 |
| D6740 | CROWN - PORCELAIN/CERAMIC | $295 |
| D6750 | CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL* | $295 |
| D6751 | CROWN - PORCELAIN FUSED PREDOMINANTLY BASE METAL | $275 |
| D6752 | CROWN - PORCELAIN FUSED NOBLE METAL* | $295 |
| D6780 | CROWN - 3/4 CAST HIGH NOBLE METAL* | $285 |
| D6781 | CROWN - 3/4 CAST PREDOMINANTLY BASE METAL | $270 |
| D6782 | CROWN - 3/4 CAST NOBLE METAL* | $285 |
| D6783 | CROWN - 3/4 PORCELAIN/CERAMIC | $285 |
| D6790 | CROWN - FULL CAST HIGH NOBLE METAL* | $295 |
| D6791 | CROWN - FULL CAST BASE METAL | $275 |
| D6792 | CROWN - FULL CAST NOBLE METAL | $295 |
| D6794 | CROWN TITANIUM* | $295 |
| D6920 | CONNECTOR BAR | $215 |
| D6930 | RECEMENT FIXED PARTIAL DENTURE | $15 |
| D6940 | STRESS BREAKER | $15 |
| D6980 | FIXED PARTIAL DENTURE REPAIR | $65 |
| **IMPLANT SERVICES** | | |
| D6010 | SURGICAL PLACEMENT OF IMPLANT BODY/ENDOSTEAL IMPLANT | $1,950 |
| D6013 | SURGICAL PLACEMENT OF A MINI-IMPLANT | $1,950 |
| D6052 | SEMI-PRECISION ATTACHMENT ABUTMENT | $368 |
| D6053 | IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR COMPLETELY EDENTULOUS ARCH | $1,840 |
| D6054 | IMPLANT/ABUTMENT SUPPORTED BY REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH | $1,840 |
| D6055 | CONNECTING BAR-IMPLANT SUPPORTED/ABUTMENT SUPPORTED | $540 |
| D6056 | PREFABRICATED/ABUTMENT INCLUDING MODIFICATION/PLACEMENT | $368 |
| D6057 | CUSTOM FABRICATED ABUTMENT - INCLUDES IMPLANT | $610 |
| D6058 | ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN | $1,050 |
| D6059 | ABUTMENT SUPPORTED PORCELAIN FUSED METAL CROWN (HIGH NOBLE METAL)* | $915 |
| D6060 | ABUTMENT SUPPORTED PORCELAIN METAL CROWN (PREDOMINANTLY BASE METAL) | $1,050 |
| D6061 | ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)* | $946 |
| D6062 | ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)* | $981 |
| D6063 | ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL) | $854 |
| D6064 | ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)* | $1,168 |



  

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|---|---|---|
| D6065 | IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN | $1,144 |
| D6066 | IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)* | $1,083 |
| D6067 | IMPLANT SUPPORTED METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)* | $962 |
| D6068 | ABUTMENT SUPPORTED RETAINER PORCELAIN/CERAMIC FPD | $1,026 |
| D6069 | ABUTMENT SUPPORTED RETAINER PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL) | $1,050 |
| D6070 | ABUTMENT SUPPORTED RETAINER PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL) | $965 |
| D6071 | ABUTMENT SUPPORTED RETAINER PORCELAIN FUSED TO METAL FPD (NOBLE METAL)* | $984 |
| D6072 | ABUTMENT SUPPORTED RETAINER CAST METAL FPD (HIGH NOBLE METAL)* | $997 |
| D6073 | ABUTMENT SUPPORTED RETAINER CAST METAL FPD (PREDOMINANTLY BASE METAL) | $910 |
| D6074 | ABUTMENT SUPPORTED RETAINER 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 (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL* | $992 |
| D6077 | IMPLANT SUPPORTED RETAINER CAST METAL FPD (TITANIUM, TITANIUM ALLOY OR HIGH NOBLE METAL)* | $962 |
| D6080 | IMPLANT MAINTENANCE PROCEDURE WHEN PROSTHESIS ARE REMOVED & INSERTED, INCLUD CLEANSING OF PROSTHESES AND ABUTMENTS | $55 |
| D6090 | REPAIR IMPLANT SUPPORTED BY PROSTHESIS, BY REPORT | $135 |
| D6091 | REPLACEMENT SEMI-PRECISION OR PRECISION ATTACHMENT IMPLANT/ABUTMENT PROSTHESIS BY REPORT | $410 |
| D6092 | RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN | $79 |
| D6093 | RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE | $124 |
| D6094 | ABUTMENT SUPPORTED CROWN (TITANIUM)* | $810 |
| D6095 | REPAIR IMPLANT ABUTMENT, BY REPORT | $55 |
| D6100 | IMPLANT REMOVAL, BY REPORT | $600 |
| D6101 | DEBRIDEMENT OF A PERIIMPLANT DEFECT & SURFACE CLEAN EXPOSED IMPLANT SURFACE, INCLUD FLAP ENTRY & CLOSURE | $45 |
| D6102 | DEBRIDEMENT & OSSEOUS CONTOURING OF A PERIIMPLANT DEFECT; INCLDE SURFACE CLEAN OF EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE | $150 |
| D6103 | BONE GRAFT FOR REPAIR OF PERIIMPLANT DEFECT–NOT INCLUD FLAP ENTRY & CLOSURE OR, WHEN INDICATED, PLACEMENT OF BARRER MEMBRANE OR BIOLOG MATERIAL TO AID OSSEOUS REGENERATION | $350 |
| D6190 | RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT | $265 |
| D6194 | ABUTMENT SUPPORTER RETAINER CAST METAL FPD (NOBLE METAL)* | $835 |
| **ORAL SURGERY SERVICES** | | |
| D7111 | EXTRACT CORONAL REMNANTS DECIDUOUS TOOTH | $20 |
| D7140 | EXTRACT ERUPTED TOOTH/EXPOSED ROOT | $30 |
| D7210 | SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING BONE AND/OR SECTIONING TOOTH | $35 |
| D7220 | REMOVAL OF IMPACTED TOOTH - SOFT TISSUE | $85 |
| D7230 | REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY | $165 |
| D7240 | REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY | $120 |
| D7241 | REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY WITH UNUSUAL SURGICAL COMPLICATION | $195 |
| D7250 | SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) | $45 |
| D7251 | CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL | $35 |
| D7261 | PRIMARY CLOSURE OF SINUS PERFORATION | $85 |
| D7270 | TOOTH REIMPLANT AND/OR STABILIZATION ACCIDENT EVULSED OR DISPLACED TOOTH | $60 |
| D7280 | SURGICAL ACCESS OF UNERUPTED TOOTH | $70 |
| D7282 | MOBILIZATION OF ERUPTED/MALPOSITIONED TEETH | $45 |
| D7285 | BIOPSY OF ORAL TISUE - HARD (BONE, TOOTH) | $45 |
| D7286 | BIOPSY OF ORAL TISSUE - SOFT | $45 |
| D7287 | EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION | $25 |
| D7288 | BRUSH BIOPSY, TRANSEPITHELIAL SAMPLE COLLECTION | $25 |
| D7290 | SURGICAL REPOSITIONING OF TEETH | $90 |
| D7310 | ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE | $50 |
| D7311 | ALVEOLOPLASTY CONJNCT XTRCT 1-3 TEETH | $35 |
| D7320 | ALVEOLOPLASTY NOT IN CONJUNCT W/EXTRACTIONS - 4/> TEETH/SPACE, PER QUADRANT | $65 |
| D7321 | ALVEOLOPLASTY NOT IN CONJUNCT W/XTRCT 1-3 TEETH | $45 |
| D7340 | VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) | $140 |
| D7350 | VESTIBULOPLASTY - RIDGE EXTENSION | $230 |
| D7450 | REMOVAL BENIGN ODONTOGENIC CYST/TUMOR UP TO 1.25 CM | $140 |
| D7451 | REMOVAL BENIGN ODONTOGENIC CYST/TUMOR >1.25 CM | $215 |
| D7460 | REMOVAL BENIGN NONODONTOGENIC CYST/TUMOR UP TO 1.25 CM | $145 |
| D7461 | REMOVAL BENIGN NONODONTOGENIC CYST/TUMOR >1.25 CM | $230 |
| D7471 | REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE) | $130 |
| D7472 | REMOVAL OF TORUS PALATINUS | $215 |
| D7473 | REMOVAL OF TORUS MANDIBULARIS | $130 |
| D7485 | SURGICAL REDUCTION OF OSSEOUS TUBEROSITY | $175 |
| D7510 | INCISION & DRAINAGE ABSCESS-INTRAORAL SOFT TISSUE | $45 |
| D7511 | INCISION & DRAINAGE ABSCESS INTRAORAL SOFT TISSUE COMPLICATED | $45 |
| D7520 | INCISION & DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE | $70 |
| D7521 | INCISION & DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE COMPLICATED | $70 |
| D7530 | REMOVAL FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE | $45 |
| D7910 | REMOVAL OF REACTION PRODUCING FOREIGN BODIES, MUSCULOSKELETAL SYSTEM | $15 |
| D7960 | FRENULECTOMY-ALSO KNOWN AS FRENECTOMY OR FRENOTOMY-SEPAR PROCED NOT INCIDENTAL TO ANOTHER | $45 |
| D7963 | FRENULOPLASTY | $45 |
| D7970 | EXCISION HYPERPLASTIC TISSUE - PER ARCH | $65 |
| D7971 | EXCISION OF PERICORONAL GINGIVA | $55 |
| D7972 | SURGICAL REDUCTION FIBROUS TUBEROSITY | $140 |
| **ADJUNCTIVE GENERAL SERVICES** | | |
| D9110 | PALLIATVE TREATMENT DENTAL PAIN - MINOR PROCEDURE | $20 |
| D9120 | FIXED PARTIAL DENTURE SECTIONING | $45 |
| D9210 | LOCAL ANESTHESIA NOT IN CONJUNCT W/OPERATIVE. SURGICAL PROCEDURE | $10 |
| D9211 | REGIONAL BLOCK ANESTHESIA | $10 |



  

| ADA | DESCRIPTION | MEMBER'S COPAYMENT |
|---|---|---|
| D9212 | TRIGEMINAL DIVISION BLOCK ANESTHESIA | $15 |
| D9215 | LOCAL ANESTHESIA IN CONJUNCTION W TH OPERATIVE OR SURGICAL PROCEDURE | $5 |
| D9220 | DEEP SEDATION/GENERAL ANESTHESIA - 1ST 30 MIN | $80 |
| D9221 | DEEP SEDATION/GENERAL ANESTHESIA-EACH ADDL15 MIN | $40 |
| D9230 | INHALATION OF NITROUS OXIDE/ANALGESIA, ANXIOLYSIS | $20 |
| D9241 | IV CONSCIOUS SEDATION/ANALGESIA -1ST 30 MIN | $55 |
| D9242 | IV CONSCIOUS SEDATION/ANALGESIA EACH ADDL 15 MIN | $25 |
| D9248 | NON-INTRAVENOUS CONSCIOUS SEDATION | $40 |
| D9310 | CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST/ PHYSICIAN OTHER THAN REQUST DENTIST/PHYSICIAN | $10 |
| D9430 | OFFICE VISIT - OBSERV - NO OTHER SERVICES PERFORMED | $10 |
| D9440 | OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS | $35 |
| D9930 | TREATMENT OF COMPLICATIONS - POST SURGICAL | $0 |
| D9940 | OCCLUSAL GUARD BY REPORT | $100 |
| D9951 | OCCLUSAL ADJUSTMENT - LIMITED | $20 |
| D9952 | OCCLUSAL ADJUSMENT - COMPLETE | $55 |
| D9971 | ODONTOPLASTY - ONE TO THREE TEETH | $20 |
| D9972 | EXTERNAL BLEACHING - PER ARCH | $125 |
| **ORTHODONTIC SERVICES** | | |
| D8070 | COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIOINAL DENTITION | $2,250 |
| D8080 | COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION | $2.250 |
| D8090 | COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION | $2,250 |
| D8680 | ORTHODONTIC RETENTION (REMOVAL OF APPLICANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S) | $150 |
| D8999 | START-UP FEE (INCLUDING EXAM, BEGINNING RECORDS, X-RAYS, TRACING, PHOTOS, AND MODELS | $350 |



*An additional charge for the cost of precious metal will be applied for any procedure using noble, high noble, or titanium metal not to exceed $150 per unit .

  

# 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. INTRAORAL - Complete Series (including bitewings) - Limited to 1 time in any 2-year period.
3. INTRAORAL BITEWING RADIOGRAPHS - Limited to 1 series of 4 films in any 6 month period.
4. FLUORIDE TREATMENTS - Limited to 1 time per 6 months.
5. SCALING AND ROOT PLANING - Limited to 4 quadrants per calendar year.
6. PERIODONTAL MAINTENANCE PROCEDURES - Limited to once every 6 months, following active therapy, exclusive of gross debridement.
7. REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (Major 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.
8. 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.
9. CROWNS - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
10. CROWNS - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
11. TEMPORARY CROWNS - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
12. INLAYS/ONLAYS - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
13. INLAYS/ONLAYS - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14. 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.
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 Charges.
16. POST AND CORES - Covered only for teeth that have had root canal therapy.
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 lesion, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS, ONLAYS, AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROSTHESIS - 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.
21. 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 financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.



  

## Exclusion 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 Dental Services or Procedures not listed in the Schedule of CoveredDental Services.
3. Any Dental Procedure not performed in a dental setting. This will not apply to Covered Emergency Dental Services.
4. Any Dental Procedure not directly associated with dental disease.
5. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
6. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
7. 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
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
10. Removable Prosthetics/Fixed Prosthetics/Crowns, Inlays and Onlays (Major Restorative Services) - The plan provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, the Covered Person must pay: (a) the Copayment for the inlay, onlay, crown or fixed bridge; and (b) an added charge equal to the actual laboratory cost of the high noble metal.
11. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
12. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
13. 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.
14. 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.
15. 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.
16. 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.
17. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
18. 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.
19. 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.
20. 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.
21. Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.

## 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.

1. The following are not covered orthodontic benefits:
   - Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
   - Treatment in progress prior to the effective date of this coverage
   - 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 treatment of accident
   - Palatal expansion appliances
   - Services performed by outside laboratories

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 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.



  