

ADA	DESCRIPTION	MEMBER'S COPAYMENT	ADA	DESCRIPTION	MEMBER'S COPAYMENT
DIAGNOSTIC SERVICES			RESTORATIVE SERVICES*		
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D2335	RSN COMPOS-4/> SURF/W/INCISAL ANG	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0	D2390	RESIN COMPOS CROWN ANTERIOR	\$40
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D2391	RESIN COMPOS - 1 SURFACE POSTERIOR	\$40
D0160	DTL&EXT ORAL EVAL - PROB FOCUS RPT	\$0	D2392	RESIN COMPOS - 2 SURFACES POSTERIOR	\$45
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D2393	RESIN COMPOS - 3 SURFACES POSTERIOR	\$75
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D2394	RESIN COMPOS - 4/MORE SURFACES POST	\$75
D0210	INTRAORAL-COMPLETE SERIES	\$0	D2510	INLAY - METALLIC - ONE SURFACE	\$175
D0220	INTRAORAL PERIAPICAL FIRST FILM	\$0	D2520	INLAY - METALLIC - TWO SURFACES	\$175
D0230	INTRAORL PERIAPICAL EA ADD FILM	\$0	D2530	INLAY - METALLIC - 3/MORE SURFACES	\$175
D0240	INTRAORAL - OCCLUSAL FILM	\$0	D2542	ONLAY - METALLIC - TWO SURFACES	\$225
D0250	EXTRAORAL - FIRST FILM	\$0	D2543	ONLAY METALLIC THREE SURFACES	\$225
D0260	EXTRAORAL - EACH ADDITIONAL FILM	\$0	D2544	ONLAY METALLIC FOUR OR MORE SURF	\$225
D0270	BITEWING - SINGLE FILM	\$0	D2610	INLAY - PORCELN/CERAMIC - 1 SURFACE	\$250
D0272	BITEWINGS - TWO FILMS	\$0	D2620	INLAY - PORCELN/CERAMIC - 2 SURF	\$250
D0273	BITEWINGS - THREE FILMS	\$0	D2630	INLAY - PORCELN/CERAM - 3/MORE SURF	\$250
D0274	BITEWINGS - FOUR FILMS	\$0	D2642	ONLAY - PORCELN/CERAMIC - 2 SURF	\$250
D0277	VERTICAL BITEWINGS - 7 TO 8 FILMS	\$0	D2643	ONLAY - PORCELN/CERAMIC - 3 SURF	\$250
D0330	PANORAMIC FILM	\$0	D2644	ONLAY - PORCELN/CERAM - 4/MORE SURF	\$250
D0415	COLLECT MICROORAGNISMS CULT & SENS	\$0	D2650	INLAY-RSN COMPOS COMPOS/RSN-1 SURF	\$250
D0425	CARIES SUSCEPTIBILITY TESTS	\$0	D2651	INLAY-RSN COMPOS COMPOS/RSN-2 SURF	\$250
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20	D2652	INLAY-RSN COMPOS COMPOS/RSN-3/>SURF	\$250
D0460	PULP VITALITY TESTS	\$0	D2662	ONLAY-RSN COMPOS COMPOS/RSN-2 SURF	\$250
D0470	DIAGNOSTIC CASTS	\$0	D2663	ONLAY-RSN COMPOS COMPOS/RSN-3 SURF	\$250
D0472	ACCESS TISS-GROSS EXAM-PREP & REPRT	\$0	D2664	ONLAY-RSN COMPOS COMPOS/RSN-4/>	\$250
D0473	ACCESS TISS-GROSS/MICRO-PREP/REPRT	\$0	D2710	CROWN RESINBASED COMPOSITE INDIRECT	\$150
D0474	ACSS TISS GR&MIC SURG MARG PREP/RPT	\$0	D2712	CROWN 3/4 RESNBASED COMPOS INDIRECT	\$150
D0999	OFFICE VISIT FEE - PER VISIT	\$0	D2720	CROWN - RESIN WITH HIGH NOBLE METAL*	\$250
PREVENTIVE SERVICES			D2721	CROWN - RESIN W/PREDOM BASE METAL	\$250
D1110	PROPHYLAXIS - ADULT <sup>1</sup>	\$0	D2722	CROWN - RESIN WITH NOBLE METAL*	\$250
-----	PROPHYLAXIS - ADULT <sup>1</sup> Add. Prophy within 6 months	\$25	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$300
D1120	PROPHYLAXIS - CHILD <sup>1</sup>	\$0	D2750	CROWN - PORCELN FUSED HI NOBLE METL*	\$250
-----	PROPHYLAXIS - CHILD <sup>1</sup> Add. Prophy within 6 months	\$25	D2751	CROWN-PORCELN FUSD PREDOM BASE METL	\$250
D1203	TOP FLUORIDE - CHILD	\$0	D2752	CROWN - PORCELAIN FUSED NOBLE METAL *	\$250
D1204	TOP FLUORIDE - ADULT	\$0	D2780	CROWN - 3/4 CAST HIGH NOBLE METAL*	\$250
D1206	TOP FLUORIDE; TX APPL MOD-HI RISK	\$0	D2781	CROWN - 3/4 CAST PREDOM BASE METL	\$250
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0	D2782	CROWN - 3/4 CAST NOBLE METAL *	\$250
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$250
D1330	ORAL HYGIENE INSTRUCTIONS	\$0	D2790	CROWN - FULL CAST HIGH NOBLE METAL*	\$250
D1351	SEALANT - PER TOOTH	\$8	D2791	CROWN - FULL CAST PREDOM BASE METL	\$250
D1510	SPACE MAINTAINER - FIXED-UNILATERAL	\$25	D2792	CROWN - FULL CAST NOBLE METAL *	\$250
D1515	SPACE MAINTAINER - FIXED-BILATERAL	\$25	D2794	CROWN TITANIUM *	\$250
D1520	SPACE MAINTAINER - REMOVABLE-UNI	\$40	D2910	RECEMENT INLAY ONLAY/PART COV REST	\$0
D1525	SPACE MAINTAINER - REMOVABLE-BIL	\$40	D2915	RECEMENT CAST/PREFAB POST & CORE	\$0
D1550	RECEMENTATION OF SPACE MAINTAINER	\$15	D2920	RECEMENT CROWN	\$0
D1555	REMOVAL OF FIXED SPACE MAINTAINER	\$15	D2930	PRFABR STAINLESS STEEL CROWN-PRIM	\$25
RESTORATIVE SERVICES*			D2931	PRFABR STAINLESS STEEL CROWN-PERM	\$25
D2140	AMALGAM-ONE SURFACE PRIMARY/PERM	\$0	D2932	PREFABRICATED RESIN CROWN	\$40
D2150	AMALGAM-TWO SURFACES PRIMARY/PERM	\$0	D2933	PRFABR STNLSS STEEL CROWN RSN WINDOW	\$40
D2160	AMALGAM-3 SURFACES PRIMARY/PERM	\$0	D2940	SEDATIVE FILLING	\$0
D2161	AMALGAM-FOUR/MORE SURF PRIM/PERM	\$0	D2950	CORE BUILDUP INCLUDING ANY PINS	\$50
D2330	RESIN COMPOS - ONE SURFACE ANTERIOR	\$0	D2951	PIN RETN - PER TOOTH ADDITION REST	\$10
D2331	RESIN COMPOS - 2 SURFACES ANTERIOR	\$0	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$40
D2332	RESIN COMPOS - 3 SURFACES ANTERIOR	\$0	D2953	EA ADD INDIRECT FAB POST SAME TOOTH	\$40

ADA	DESCRIPTION	MEMBER'S COPAYMENT	ADA	DESCRIPTION	MEMBER'S COPAYMENT
D2954	PREFABR POST&CORE ADDITION CROWN	\$25		REMOVEABLE PROSTHODONTICS SERVICES*	
D2955	POST REMOVAL	\$10	D5211	MAX PARTIAL DENTURE - RESIN BASE	\$250
D2957	EA ADD PREFABR POST - SAME TOOTH	\$30	D5212	MAND PARTIAL DENTUR - RESIN BASE	\$250
D2970	TEMPORARY CROWN	\$0	D5213	MAX PART DENTUR-CAST METL W/RSN	\$325
D2971	ADD PROC NEW CROWN XST PART DENTURE	\$50	D5214	MAND PART DENTUR- CAST METL W/RSN	\$325
	ENDODONTIC SERVICES		D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$325
D3110	PULP CAP - DIRECT	\$0	D5226	MANDIBULAR PART DENTURE FLEX BASE	\$325
D3120	PULP CAP - INDIRECT	\$0	D5281	REMV UNI PART DENTUR-1 PC CAST METL	\$275
D3220	TX PULPOT-CORONL DENTNOCEMENTL JUNC	\$0	D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$10
D3221	PULPAL DEBRID PRIMARY&PERM TEETH	\$30	D5411	ADJUST COMPLETE DENTUR - MANDIBULAR	\$10
D3230	PULPAL THERAPY - ANT PRIMARY TOOTH	\$40	D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$10
D3240	PULPAL THERAPY - POST PRIMARY TOOTH	\$40	D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$10
D3310	ANTERIOR	\$95	D5510	REPAIR BROKEN COMPLETE DENTURE BASE	\$30
D3320	BICUSPID	\$175	D5520	REPL MISS/BROKEN TEETH-CMPL DENTUR	\$30
D3330	MOLAR	\$305	D5610	REPAIR RESIN DENTURE BASE	\$30
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D5620	REPAIR CAST FRAMEWORK	\$30
D3332	INCML ENDO TX;INOP UNRSTR/FX TOOTH	\$85	D5630	REPAIR OR REPLACE BROKEN CLASP	\$30
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$85	D5640	REPLACE BROKEN TEETH - PER TOOTH	\$30
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$115	D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$30
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$175	D5660	ADD CLASP EXISTING PARTIAL DENTURE	\$30
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$300	D5670	REPL ALL TEETH&ACRYLC FRMEWRK MAX	\$150
D3351	APEXIFICAT/RECALCIFICAT - INIT VST	\$70	D5671	REPL ALL TEETH&ACRYLC FRMEWRK MAND	\$150
D3352	APEXIFICAT/RECALCIFICAT-INTERIM	\$70	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$65
D3353	APEXIFICAT/RECALCIFICAT-FINAL VISIT	\$70	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$65
D3410	APICOECT/PERIRADICULAR SURG - ANT	\$95	D5720	REBASE MAXILLARY PARTIAL DENTURE	\$65
D3421	APICOECT/PERIRADICULR SURG-BICUSPID	\$95	D5721	REBASE MANDIBULAR PARTIAL DENTURE	\$65
D3425	APICOECT/PERIRADICULAR SURG - MOLAR	\$95	D5730	RELIN CMPL MAXIL DENTURE CHAIRSIDE	\$55
D3426	APICOECTOMY/PERIRADICULAR SURGERY	\$55	D5731	RELIN CMPL MAND DENTURE CHAIRSIDE	\$55
D3430	RETROGRADE FILLING - PER ROOT	\$55	D5740	RELIN MAXIL PART DENTURE CHAIRSIDE	\$55
D3450	ROOT AMPUTATION - PER ROOT	\$95	D5741	RELIN MAND PART DENTURE CHAIRSIDE	\$55
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15	D5750	RELIN CMPL MAXIL DENTURE LAB	\$75
D3920	HEMISECTION NOT INCL RC THERAPY	\$90	D5751	RELIN CMPL MAND DENTRUE LABORATORY	\$75
D3950	CANAL PREP&FIT PREFORMED DOWEL/POST	\$15	D5760	RELIN MAXIL PART DENTURE LAB	\$75
	PERIODONTIC SERVICES		D5761	RELIN MAND PART DENTURE LABORATORY	\$75
D4210	GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	\$115	D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$115
D4211	GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	\$80	D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$115
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$150	D5850	TISSUE CONDITIONING MAXILLARY	\$20
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$95	D5851	TISSUE CONDITIONING MANDIBULAR	\$20
D4245	APICALLY POSITIONED FLAP	\$165		FIXED PROSTHODONTICS SERVICES*	
D4249	CLIN CROWN LEN - HARD TISSUE	\$145	D6210	PONTIC - CAST HIGH NOBLE METAL*	\$250
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$325	D6211	PONTIC - CAST PREDOM BASE METAL	\$250
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$225	D6212	PONTIC - CAST NOBLE METAL *	\$250
D4263	BONE REPLCMT GRAFT - 1 SITE QUAD	\$175	D6214	PONTIC TITANIUM *	\$250
D4264	BN REPLCMT GRAFT - EA ADD SITE QUAD	\$90	D6240	PONTIC-PORCLN FUSED HI NOBLE METL *	\$250
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$225	D6241	PONTIC-PORCLN FUSD PREDOM BASE METL	\$250
D4271	FREE SOFT TISSUE GRAFT PROCEDURE	\$225	D6242	PONTIC - PORCLN FUSED NOBLE METAL *	\$250
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	\$85	D6245	PONTIC - PORCELAIN/CERAMIC	\$300
D4341	PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	\$45	D6250	PONTIC - RESIN W/HIGH NOBLE METAL *	\$250
D4342	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	\$45	D6251	PONTIC RESIN W/PREDOM BASE METAL	\$250
D4355	FULL MOUTH DEBRID COMP EVAL&DX	\$50	D6252	PONTIC RESIN W/NOBLE METAL *	\$250
D4381	LOC DEL ANTIMICROBIAL AGT TOOTH BR	\$55	D6600	INLAY-PORCELAIN/CERAMIC 2 SURFACES	\$270
D4910	PERIODONTAL MAINTENANCE	\$30	D6601	INLAY - PORCLN/CERAMIC 3/MORE SURF	\$270
D4920	UNSCHEDULED DRESSING CHANGE	\$0	D6602	INLAY - CAST HI NOBLE METAL 2 SURF	\$175
	REMOVEABLE PROSTHODONTICS SERVICES*		D6603	INLAY-CAST HI NOBLE METL 3/> SURF	\$175
D5110	COMPLETE DENTURE - MAXILLARY	\$275	D6604	INLAY-CAST PREDOM BASE METL 2 SURF	\$175
D5120	COMPLETE DENTURE - MANDIBULAR	\$275	D6605	INLAY-CAST PREDOM BASE METL 3/>SURF	\$175
D5130	IMMEDIATE DENTURE - MAXILLARY	\$315	D6606	INLAY - CAST NOBLE METAL 2 SURFACES	\$175
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$315	D6607	INLAY - CAST NOBLE METL 3/MORE SURF	\$175

ADA	DESCRIPTION	MEMBER'S COPAYMENT	ADA	DESCRIPTION	MEMBER'S COPAYMENT
FIXED PROSTHODONTICS SERVICES*			ORAL SURGERY SERVICES		
D6608	ONLAY - PORCELN/CERAMIC 2 SURFACES	\$280	D7473	REMOVAL OF TORUS MANDIBULARIS	\$65
D6609	ONLAY - PORCELN/CERAMIC 3/MORE SURF	\$280	D7485	SURGICAL RDOC OSSEOUS TUBEROSITY	\$65
D6610	ONLAY - CAST HI NOBLE METAL 2 SURF	\$175	D7510	I&D ABSCESS-INTRAORAL SOFT TISS	\$35
D6611	ONLAY-CAST HI NOBLE METL 3/> SURF	\$175	D7511	I & D ABS INTRAORAL SOFT TISS COMP	\$35
D6612	ONLAY-CAST PREDOM BASE METL 2 SURF	\$175	D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25
D6613	ONLAY-CAST PREDOM BASE METL 3/>SURF	\$175	D7960	FRENULECTOMY SEPARATE PROCEDURE	\$45
D6614	ONLAY - CAST NOBLE METAL 2 SURFACES	\$175	D7963	FRENULOPLASTY	\$45
D6615	ONLAY - CAST NOBLE METL 3/MORE SURF	\$175	D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$55
D6624	INLAY TITANIUM	\$250	D7971	EXCISION OF PERICORONAL GINGIVA	\$40
D6634	ONLAY TITANIUM	\$250	D7972	SURGICAL RDOC FIBROUS TUBEROSITY	\$100
D6720	CROWN - RESIN WITH HIGH NOBLE METAL *	\$250	ADJUNCTIVE GENERAL SERVICES		
D6721	CROWN RESIN PREDOM BASE METL-DENTUR	\$250	D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10
D6722	CROWN - RESIN WITH NOBLE METAL *	\$250	D9211	REGIONAL BLOCK ANESTHESIA	\$0
D6740	CROWN - PORCELAIN/CERAMIC	\$300	D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0
D6750	CRWN PORCLN FUSD HI NOBL MTL-DENTUR *	\$250	D9215	LOCAL ANESTHESIA	\$0
D6751	CROWN-PORCELN FUSD PREDOM BASE METL	\$250	D9220	DP SEDATION/GEN ANES-1ST 30 MIN	\$155
D6752	CROWN - PORCELAIN FUSED NOBLE METAL *	\$250	D9221	DP SEDAT/GEN ANES-EA ADD 15 MIN	\$75
D6780	CROWN - 3/4 CAST HIGH NOBLE METAL *	\$250	D9241	IV CONSC SEDAT/ANALG -1ST 30 MIN	\$155
D6781	CROWN-3/4 CAST PREDOM BASED METAL	\$250	D9242	IV CONSC SEDAT/ANALG-EA ADD 15 MIN	\$70
D6782	CROWN 3/4 CAST NOBLE METAL-DENTURE *	\$250	D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0
D6783	CROWN 3/4 PORCELAIN/CERAMIC-DENTURE	\$300	D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5
D6790	CROWN FULL CAST HI NOBL METL-DENTUR *	\$250	D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35
D6791	CROWN FULL CAST BASE METAL-DENTURE	\$250	D9450	CASE PRSATION DTL&EXT TX PLANNING	\$0
D6792	CROWN FULL CAST NOBLE METAL-DENTURE *	\$250	D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0
D6794	CROWN TITANIUM *	\$250	D9940	OCCLUSAL GUARD BY REPORT	\$85
D6930	RECEMENT FIXED PARTIAL DENTURE	\$0	D9951	OCCLUSAL ADJUSTMENT - LIMITED	\$30
D6940	STRESS BREAKER	\$125	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$90
D6970	POST&CORE ADD FIX PART DENTURE RET	\$50	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
D6972	PRFAB POST&COR ADD PART DENTUR RETN	\$30	D9999	BROKEN APPOINTMENT	\$20
D6973	CORE BUILD UP RETAIN INCL ANY PINS	\$10	ORTHODONTIC SERVICES		
D6976	EA ADD INDIRECT FAB POST SAME TOOTH	\$50	D8070	Comprehensive orthodontic treatment transitional dentition	\$1,895
D6977	EACH ADD PRFAB POST SAME TOOTH	\$50	D8080	Comprehensive orthodontic treatment adolescent dentition	\$1,895
ORAL SURGERY SERVICES			D8090	Comprehensive orthodontic treatment adult dentition	\$1,895
D7111	XTRCT CORONL RMNNTS DECIDUOUS TOOTH	\$8	D8680	Orthodontic retention (removal of appliances, construction, and placement of retainers)	\$300
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$8	D8999	Start-up fee (including exam, beginning records, x-rays, tracing, photos, and models)	\$250
D7210	SURG REMOVAL ERUPTED TOOTH	\$30	D8999	Post Treatment Records	\$150
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	\$55			
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$85			
D7240	REMOVAL IMPACTED TOOTH - CMPL BONY	\$125			
D7241	REMV IMP TOOTH-CMPL BNY W/SURG COMP	\$150			
D7250	SURG REMOVAL RESIDUAL TOOTH ROOTS	\$40			
D7270	TOOTH REIMPL&/STBL ACC DISPLCD	\$50			
D7280	SURGICAL ACCESS AN UNERUPTED TOOTH	\$85			
D7282	MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	\$90			
D7285	BIOPSY OF ORAL TISSUE HARD	\$150			
D7286	BIOPSY OF ORAL TISSUE SOFT	\$60			
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	\$40			
D7311	ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	\$15			
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$60			
D7321	ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	\$25			
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$85			
D7472	REMOVAL OF TORUS PALATINUS	\$65			

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

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

# UnitedHealthcare Dental/HMO 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. **INTRAORAL COMPLETE SERIES OR PANOREX** - Limited to 1 time in any 2-year period.
3. **BITEWING RADIOGRAPHS** - Limited to 1 series of 4 films per 6 months.
4. **DENTAL PROPHYLAXIS** - Limited to 1 time per 6 months.
5. **FLUORIDE TREATMENTS** - Limited to 1 time per calendar year.
6. **SCALING AND ROOT PLANING** - Limited to 4 quadrants per calendar year.
7. **PERIODONTAL MAINTENANCE PROCEDURES** - Limited to 1 time per 6 months, following active therapy, exclusive of gross debridement.
8. **REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS** - 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.
9. **REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS** - 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.
10. **CROWNS** - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
11. **CROWNS** - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
12. **TEMPORARY CROWNS** - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
13. **INLAYS/ONLAYS** - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
14. **INLAYS/ONLAYS** - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
15. **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.
16. **CROWNS AND FIXED BRIDGES** - 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.
17. **POST AND CORES** - Covered only for teeth that have had root canal therapy.
18. **ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS** - Limited to repairs or adjustments performed more than 6 months after the initial insertion.
19. **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).
20. **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.
21. **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 request for specialist referral is denied, the PCD 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 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.



## 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. Cost for non-Dental Services related to the provision of Dental Services in hospitals, extended care facilities, or Subscriber's home. When deemed Necessary by the Primary Care Dentist, the Subscriber's Physician and authorized by us, Covered Dental Services that are delivered in an inpatient or outpatient hospital setting are Covered as indicated in the Schedule of Covered Services.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. 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.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a participating dental setting. This will not apply to Covered Emergency Dental Services.
7. 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.
8. Placement of dental implants, implant-supported abutments and prostheses.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. 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.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. 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.
13. 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
14. 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.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Contract.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Services rendered by a provider who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
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. Foreign Services are not Covered unless required as an Emergency.
24. 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.
25. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
26. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
27. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by a PCD; or (b) treatment by a specialist without referral from a PCD and our approval.
28. Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
29. Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.
30. Consultations for non-Covered services.
31. A service started but not completed prior to the Covered Person's eligibility to receive benefits under the plan. Inlays, onlays and fixed bridges are considered started when the tooth or teeth are prepared. Root canal treatment is considered started when the pulp chamber is opened. Orthodontics are considered started at the time of initial banding. Dentures are considered started when the impressions are taken.
32. A service started (as defined above) by a Non-Participating Dentist. This will not apply to Covered Emergency Dental Services.
33. Procedures performed to facilitate non-Covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft
34. 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.
35. Relative analgesia (N2O2- nitrous oxide).

## 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 benefit 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 first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period. 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.