UnitedHealthcare®
In Network Only National Options PPO 20 Network/covered dental services

dental plan
PI096 /MAC

	NON-ORTHODONTICS NETWORK	ORTHODONTICS NETWORK OR NON-NETWOR
Individual Annual Deductible	$0	$0
Family Annual Deductible	$0	
Annual Maximum Benefit *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$5000 per person per Plan Year	$2000 per person per Lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No	
Annual Deductible Applies to Orthodontic Services	No	
Waiting Period	No waiting period	
Orthodontic Eligibility Requirement	Adult & Child	
Orthodontic Services (Diagnose or correct misaligment of teeth or bite)	50%	50%

ADA	DESCRIPTION	MEMBER PAYS*	
DIAGNOSTIC SERVICES			
D0120	PERIODIC ORAL EVALUATION EST PT	$0	$22
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$0	$22
D0145	ORAL EVAL PT<3 AND COUNSEL	$0	$36
D0150	COMP ORAL EVALUATION - NEW/EST PT	$0	$36
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS REPORT	$0	$50
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	$0	$30
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE VISIT	$0	$30
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	$0	$42
D0190	SCREENING OF A PATIENT	$0	$0
D0191	ASSESMENT OF A PATIENT	$0	$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC IMAGES	$0	$58
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$0	$12
D0230	INTRAORL PERIAPICAL EACH ADD RADIOGRAPHIC IMAGE	$0	$10
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$0	$28
D0260	EXTRAORAL - EACH ADDITIONAL RADIOGRAPHIC IMAGE	$0	$27
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0	$13
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0	$19
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0	$28
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0	$28
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$0	$50
D0290	POSTERIOR - ANTERIOR OR LATERAL SKULL AND FACIAL SURVEY RADIOGRAPHIC IMAGE	$0	
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$0	$54
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$0	$60
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY	$0	$30
D0351	3D PHOTOGRAPHIC IMAGE	$0	$145
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	
D0411	HbA1c IN-OFFICE POINT OF SERVICE TESTING	$0	
D0414	LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0	$33
D0415	COLLECT MICROORGANISMS CULT & SENS	$0	$33
D0416	VIRAL CULTURE	$0	$33
D0417	COLLECTION & PREP OF SALIVA SAMPLE	$0	
D0418	ANALYSIS OF SALIVA SAMPLE	$0	

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ADA	DESCRIPTION	MEMBER PAYS*	
D0425	CARIES SUSCEPTIBILITY TESTS	$0	$33
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$0	$40
D0460	PULP VITALITY TESTS	$0	$27
D0470	DIAGNOSTIC CASTS	$0	$56
D0472	ACCESS TISSUE, GROSS EXAM - PREP & REPORT	$0	
D0473	ACCESS TISSUE, GROSS & MICROSCOPIC - PREP/REPORT	$0	
D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	$0	
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$0	
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$0	
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$0	
D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	$0	$54
D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	$0	$60
D0703	2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE INTRA-ORALLY OR EXTRA-ORALLY–IMAGE CAPTURE ONLY	$0	$30
D0704	3-D PHOTOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0	$145
D0707	INTRAORAL–PERIAPICAL RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	$0	$12
D0708	INTRAORAL–BITEWING RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0	$13
D0709	INTRAORAL–COMPLETE SERIES OF RADIOGRAPHIC IMAGES–IMAGE CAPTURE ONLY	$0	$58
PREVENTIVE SERVICES			
D1110	PROPHYLAXIS - ADULT	$0	$46
D1120	PROPHYLAXIS - CHILD	$0	$33
D1206	TOPICALFLUORIDE VARNISH	$0	$18
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$0	
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	$0	
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	$0	
D1321	COUNSEL FOR CONTROL-PREVENTION ADVERSE ORAL, BEHAVIORAL, AND SYSTEMIC HEALTH EFFECTS ASSCTED W/HIGH-RISK SUBSTANCE USE	$0	
D1330	ORAL HYGIENE INSTRUCTIONS	$0	
D1351	SEALANT - PER TOOTH	$0	$23
D1352	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$0	
D1353	SEALANT REPAIR – PER TOOTH	$0	
D1510	SPACE MAINTAINER - FIXED, UNILATERAL/QUAD	$0	$125
D1515	SPACE MAINTAINER - FIXED - BILATERAL	$0	$185
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	$0	$185
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	$0	$185
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	$0	$165
D1525	SPACE MAINTAINER - REMOVABLE - BILATERAL	$0	$245
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	$0	$245
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	$0	$245
D1551	RECEM/REBOND BILATERAL SPACE MAINTAINER – MAXIL	$0	$23
D1552	RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB	$0	$23
D1553	RECEM/REBOND UNILATERAL SPACE MAINTAINER/QUAD	$0	$23
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER/QUAD	$0	$23
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	$0	$23
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	$0	$23
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED, UNILATERAL/QUAD	$0	$125
RESTORATIVE SERVICES			
D2140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	$5	$46
D2150	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	$5	$57
D2160	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	$10	$73
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	$10	$98
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	$5	$57
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	$5	$71
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	$10	$91
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	$10	$62
D2390	RESIN COMPOSITE CROWN ANTERIOR	$20	$100
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	$5	$80
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	$10	$60
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	$10	$40
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	$10	$40

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ADA	DESCRIPTION	MEMBER PAYS*	
D2420	GOLD FOIL - TWO SURFACES	$120	$190
D2430	GOLD FOIL - THREE SURFACES	$185	$270
D2510	INLAY - METALLIC - ONE SURFACE	$95	$210
D2520	INLAY - METALLIC - TWO SURFACES	$95	$180
D2530	INLAY - METALLIC - 3/MORE SURFACES	$95	$290
D2542	ONLAY - METALLIC - TWO SURFACES	$95	$280
D2543	ONLAY - METALLIC THREE SURFACES	$95	$310
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	$95	$335
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	$35	$250
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$40	$255
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	$45	$290
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$95	$255
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	$95	$285
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	$95	$385
D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	$30	$215
D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	$35	$220
D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	$40	$250
D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	$30	$230
D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	$40	$265
D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	$45	$300
D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	$20	$115
D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	$20	$115
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	$40	$310
D2721	CROWN - RESIN W/PREDOM BASE METAL	$30	$280
D2722	CROWN - RESIN WITH NOBLE METAL	$30	$300
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$100	$350
D2750	CROWN - PORCELAIN FUSED HI NOBLE METAL	$100	$315
D2751	CROWN - PORCELAIN FUSED PREDOM BASE METAL	$90	$275
D2752	CROWN - PORCELAIN FUSED NOBLE METAL	$100	$285
D2753	CROWN PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$100	$285
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	$95	$335
D2781	CROWN - 3/4 CAST PREDOM BASE METAL	$90	$295
D2782	CROWN - 3/4 CAST NOBLE METAL	$95	$315
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$95	$315
D2790	CROWN - FULL CAST HIGH NOBLE METAL	$100	$295
D2791	CROWN - FULL CAST PREDOM BASE METAL	$90	$255
D2792	CROWN - FULL CAST NOBLE METAL	$100	$275
D2794	CROWN - TITANIUM AND TITANIUM ALLOYS	$100	$320
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$5	$40
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFABRICATED POST & CORE	$5	$40
D2920	RECEMENT OR RE-BOND CROWN	$5	$40
D2921	REATTACHMENT OF TOOTH FRAGMENT	$5	$40
D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	$10	
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	$10	$90
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	$10	$110
D2932	PREFABRICATED RESIN CROWN	$10	$130
D2933	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	$10	$140
D2934	PREFABRICATED ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	$10	$120
D2940	SEDATIVE FILLING	$5	$46
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$5	
D2950	CORE BUILDUP INCLUDING ANY PINS	$5	$80
D2951	PIN RETENTION - PER TOOTH ADDITION REST	$5	$10
D2952	POST & CORE ADD CROWN INDIRECT FAB	$25	$140
D2953	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	$5	$200
D2954	PREFABRICATED POST & CORE ADDITION CROWN	$10	$95
D2955	POST REMOVAL	$20	$145
D2957	EACH ADD PREFABR POST - SAME TOOTH	$5	$35
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	$20	
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	$40	
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	$40	

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ADA	DESCRIPTION	MEMBER PAYS*	
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER XST PART DENTURE	$10	
D2975	COPING	$70	$205
D2980	CROWN REPAIR	$15	$55
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$10	
ENDODONTIC SERVICES			
D3110	PULP CAP - DIRECT	$0	$27
D3120	PULP CAP - INDIRECT	$0	$25
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL JUNC	$0	$72
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT TEETH	$5	$72
D3222	PARTIAL PULPOTOMY	$0	
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$0	$75
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$0	$90
D3310	ANTERIOR	$15	$256
D3320	BICUSPID	$20	$265
D3330	MOLAR	$60	$323
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$5	$100
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$0	$110
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$5	$65
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$15	$270
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$20	$320
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$35	$390
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	$5	$105
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	$5	$75
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$10	$140
D3355	PULPAL REGENERATION - INITIAL VISIT	$5	$105
D3356	PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT	$5	$75
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	$10	$140
D3410	APICOECTOMY SURG - ANT	$15	$330
D3421	APICOECTOMY SURG-BICUSPID	$20	$325
D3425	APICOECTOMY SURG - MOLAR	$30	$375
D3426	APICOECTOMY SURGERY	$10	$95
D3430	RETROGRADE FILLING - PER ROOT	$10	$80
D3450	ROOT AMPUTATION - PER ROOT	$12	$155
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$1,950	
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	$15	$330
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR	$20	$325
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	$30	$375
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR	$13	
D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–PREMOLAR	$13	
D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–MOLAR	$13	
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$5	
D3911	INTRAORIFICE BARRIER	$5	$80
D3920	HEMISECTION NOT INCL RC THERAPY	$5	$130
D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	$5	
PERIODONTIC SERVICES			
D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	$10	$226
D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	$5	$16
D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST PROC/TOOTH	$0	
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$10	$230
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$5	$303
D4245	APICALLY POSITIONED FLAP	$10	$265
D4249	CLIN CROWN LEN - HARD TISSUE	$10	$190
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$30	$300
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$20	$410
D4263	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	$15	$205
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$10	$240

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ADA	DESCRIPTION	MEMBER PAYS*	
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$10	$210
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$15	$255
D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH	$5	
D4322	SPLINT–INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	$10	$70
D4323	SPLINT–EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	$5	$65
D4341	PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD	$5	$63
D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	$5	$81
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$0	$36
D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX ON A SUBSEQUENT VISIT	$5	$27
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$5	$55
D4910	PERIODONTAL MAINTENANCE	$0	$36
D4920	UNSCHEDULED DRESSING CHANGE	$0	$35
D4921	GINGIVAL IRRIGATION – PER QUADRANT	$0	
REMOVABLE PROSTHODONTIC SERVICES			
D5110	COMPLETE DENTURE - MAXILLARY	$140	$410
D5120	COMPLETE DENTURE - MANDIBULAR	$140	$410
D5130	IMMEDIATE DENTURE - MAXILLARY	$140	$455
D5140	IMMEDIATE DENTURE - MANDIBULAR	$140	$455
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	$40	$285
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$40	$305
D5213	MAX PART DENTUR-CAST METL W/RSN	$140	$440
D5214	MAND PART DENTUR- CAST METL W/RSN	$140	$440
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$30	
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$30	
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$30	
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$30	
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$40	$470
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	$40	$470
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX BASE	$30	
D5228	IMMEDIATE MANDIBULAR PARTIAL DENTURE-FLEX BASE	$30	
D5281	REMOVABLE UNILATERAL PARTIAL DENTURE - 1 PC CAST METAL (INCLUDING CLASPS AND TEETH)	$20	$250
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE - MAXILLARY	$20	$250
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	$20	$250
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE – FLEX BASE/QUAD	$40	$470
D5286	REMOVABLE UNILATERAL PARTIAL DENTURE-RESIN/QUAD	$40	$470
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$5	$33
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$5	$33
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$5	
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$5	$33
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	$10	$56
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$10	$56
D5520	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$5	$50
D5611	REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	$10	$62
D5612	REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	$10	$62
D5621	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$25	$81
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$25	$81
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$25	$90
D5640	REPLACE BROKEN TEETH - PER TOOTH	$10	$47
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$10	$77
D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$20	$85
D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK MAXILLARY	$45	$200
D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK MANDIBULAR	$45	$200

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ADA	DESCRIPTION	MEMBER PAYS*	
D5710	REBASE COMPLETE MAXILLARY DENTURE	$40	$220
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$40	$200
D5720	REBASE MAXILLARY PARTIAL DENTURE	$30	$200
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$30	$200
D5725	REBASE HYBRID PROSTHESIS	$40	$220
D5730	RELINE CMPL MAXIL DENTURE (DIRECT)	$25	$120
D5731	RELINE CMPL MAND DENTURE (DIRECT)	$25	$120
D5740	RELINE MAXIL PART DENTURE (DIRECT)	$20	$105
D5741	RELINE MAND PART DENTURE (DIRECT)	$20	$105
D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	$30	$140
D5751	RELINE CMPL MAND DENTURE (INDIRECT)	$30	$140
D5760	RELINE MAXIL PART DENTURE (INDIRECT)	$30	$140
D5761	RELINE MAND PART DENTURE (INDIRECT)	$30	$140
D5765	SOFT LINER FOR COMPLETE OR PART REMOVABLE DENTURE–INDIRECT	$5	$44
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$40	$200
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$40	$200
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$30	$175
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$30	$190
D5850	TISSUE CONDITIONING MAXILLARY	$5	$44
D5851	TISSUE CONDITIONING MANDIBULAR	$5	$44
D5863	OVERDENTURE - COMPLETE MAXILLARY	$140	
D5864	OVERDENTURE - COMPLETE MANDIBULAR	$140	
D5865	OVERDENTURE - PARTIAL MAXILLARY	$140	
D5866	OVERDENTURE - PARTIAL MANDIBULAR	$140	
D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE (PER ARCH)	$40	$220
IMPLANT SERVICES			
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,950	
D6011	SURGICAL ACCESS TO AN IMPLANT BODY (SECOND STAGE IMPLANT SURGERY)	$1,950	
D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	$1,950	
D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	$540	
D6056	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$368	
D6057	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$610	
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,050	
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$915	
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$1,050	
D6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$946	
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$981	
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$854	
D6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$1,168	
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,144	
D6066	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$1,083	
D6067	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	$962	
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$1,026	
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$1,050	
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$965	
D6071	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$984	
D6072	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$997	
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$910	
D6074	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$967	
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$1,018	
D6076	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$992	
D6077	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	$962	
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$55	
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	$15	

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ADA	DESCRIPTION	MEMBER PAYS*	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$1,083	
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS	$1,083	
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$1,083	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE ALLOYS	$962	
D6087	IMPLANT SUPPT CROWN-NOBLE ALLOYS	$962	
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM ALLOYS	$962	
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$135	
D6091	REPLCMT OF REPLCEABLE PART OF SEMI-PRECISION/PRECISION ATTCHMT OF IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER ATTCHMT	$410	
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	$79	
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$124	
D6094	ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	$810	
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$55	
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$20	
D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$915	
D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$992	
D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	$992	
D6100	SURGICAL REMOVAL OF IMPLANT BODY	$600	
D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$15	
D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$50	
D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	$350	
D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$1,840	
D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$1,840	
D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$1,840	
D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$1,840	
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$40	
D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$40	
D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$992	
D6121	IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS	$962	
D6122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	$962	
D6123	IMPLANT SUPPT RETAINER FOR METAL FPD-TITANIUM/TITANIUM ALLOYS	$962	
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$265	
D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	$368	
D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	$368	
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	$835	
D6195	ABUTMENT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$1,050	
FIXED PROSTHODONTIC SERVICES			
D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	$20	$110
D6210	PONTIC - CAST HIGH NOBLE METAL	$80	$310
D6211	PONTIC - CAST PREDOM BASE METAL	$75	$280
D6212	PONTIC - CAST NOBLE METAL	$80	$300
D6214	PONTIC - TITANIUM AND TITANIUM ALLOYS	$80	$310
D6240	PONTIC - PORCELAIN FUSED HI NOBLE METAL	$80	$310
D6241	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	$75	$270
D6242	PONTIC - PORCELAIN FUSED NOBLE METAL	$80	$300
D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$80	$310
D6245	PONTIC - PORCELAIN/CERAMIC	$95	$320
D6250	PONTIC - RESIN W/HIGH NOBLE METAL	$25	$300
D6251	PONTIC RESIN W/PREDOM BASE METAL	$15	$300
D6252	PONTIC RESIN W/NOBLE METAL	$15	$300
D6253	INTERIM PONTIC–FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	$25	$130
D6545	RETAINER - CASE METAL FOR RESIN FIXED PROSTHESIS	$10	$120
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	$10	$250

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ADA	DESCRIPTION	MEMBER PAYS*	
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	$10	$110
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2 SURFACES	$40	$260
D6601	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$45	$285
D6602	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	$40	$260
D6603	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	$45	$315
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	$40	$260
D6605	RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES	$45	$270
D6606	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$40	$235
D6607	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	$45	$285
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	$45	$260
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$50	$285
D6610	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	$55	$325
D6611	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	$60	$355
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	$50	$280
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	$55	$310
D6614	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$50	$295
D6615	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	$50	$325
D6624	RETAINER INLAY - TITANIUM	$45	$315
D6634	RETAINER ONLAY - TITANIUM	$75	$355
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$20	$190
D6720	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$40	$300
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$30	$300
D6722	RETAINER CROWN - RESIN WITH NOBLE METAL	$30	$300
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$100	$320
D6750	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$100	$330
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$90	$295
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$100	$305
D6753	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$100	$330
D6780	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$95	$310
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$90	$310
D6782	RETAINER CROWN - 3/4 CAST NOBLE METAL	$95	$280
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$95	$320
D6784	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	$95	$310
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$100	$315
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$90	$285
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	$100	$295
D6794	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	$100	$295
D6920	CONNECTOR BAR	$70	
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$5	$60
D6940	STRESS BREAKER	$5	$30
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$20	$100
ORAL SURGERY SERVICES			
D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	$5	$28
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$5	$51
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$5	$94
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$10	$99
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$20	$134
D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	$15	$129
D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	$25	$229
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$5	$105
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	$5	
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$10	$195
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	$10	$80
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$10	$210
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	$5	$135
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$5	$105
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$5	$95
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$5	$45
D7288	BRUSH BIOPSY	$5	$45

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ADA	DESCRIPTION	MEMBER PAYS*	
D7290	SURGICAL REPOSITIONING OF TEETH	$10	
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$5	$265
D7311	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	$5	$35
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$10	$265
D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	$5	$50
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$20	$260
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$30	$560
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$20	$120
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$30	$200
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$20	$140
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$30	$230
D7471	REMOVAL OF LATERAL EXOSTOSIS	$15	
D7472	REMOVAL OF TORUS PALATINUS	$30	$340
D7473	REMOVAL OF TORUS MANDIBULARIS	$15	$340
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$25	
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	$5	$114
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	$5	$114
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$10	$114
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$10	$135
D7530	REMOVAL OF FOREIGN BODY - SKIN SUBCUTANEOUS	$5	$60
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$0	$40
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	$5	$274
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	$5	$274
D7963	FRENULOPLASTY	$5	$135
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$10	$105
D7971	EXCISION OF PERICORONAL GINGIVA	$10	$60
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$20	$105
D7994	SURGICAL PLACEMENT: ZYGOMATIC IMPLANT	$1,950	
ADJUNCTIVE GENERAL SERVICES			
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$5	$43
D9120	FIXED PARTIAL DENTURE SECTIONING	$15	$100
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$0	$43
D9211	REGIONAL BLOCK ANESTHESIA	$0	$43
D9212	TRIGEMINAL DIVISION BLOCK ANES	$0	$43
D9215	LOCAL ANESTHESIA	$0	$12
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	$0	
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	$10	
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$5	
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$5	$20
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$10	$5
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$5	$170
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$0	$80
D9430	OV OBS - NO OTH SERVICES PERFORMED	$0	
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$5	$35
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0	
D9940	OCCLUSAL GUARD, BY REPORT	$15	$415
D9943	OCCLUSAL GUARD ADJUSTMENT	$5	
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	$15	$415
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	$15	$415
D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH	$15	$415
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$5	$95
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$5	$420
D9971	ODONTOPLASTY - PER TOOTH	$0	
D9972	EXTERNAL BLEACHING - PER ARCH PERFORMED IN OFFICE	$125	

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ADA	DESCRIPTION	MEMBER PAYS*
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME ENCOUNTER	$0
D9996	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW	$0

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage.
Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

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*The network enrollee copay will be lesser of the copay shown above and the discounted fee negotiated with the provider.

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

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Pleas the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certi Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and condition coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental® In Network Only (INO) Plan is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppage, New Yor Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United HealthCare Services, Inc.

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UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

A. Necessary;
B. Proviced by or under the direction of a Dentist or other appropriate provider as specifically described;
C. The least costly, clinically accepted treatment; and
D. Not excluded as described in the Section entitled, General Exclusions.

GENERAL LIMITATIONS

1. **PERIODIC ORAL EVALUATION** Limited to 2 times per consecutive 12 months.
2. **COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to 1 time per consecutive 36 months.
3. **BITEWING RADIOGRAPHS** Limited to 1 series of films per calendar year.
4. **EXTRAORAL RADIOGRAPHS** Limited to 2 films per calendar year.
5. **DENTAL PROPHYLAXIS** Limited to 2 times per consecutive 12 months.
6. **FLUORIDE TREATMENTS** Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
7. **SPACE MAINTAINERS** Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. **SEALANTS** Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
9. **RESTORATIONS (Amalgam or Composite)** Multiple restorations on one surface will be treated as a single filling.
10. **PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to cast restoration.
11. **INLAYS, ONLAYS, AND VENEERS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. **CROWNS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
13. **POST AND CORES** Covered only for teeth that have had root canal therapy.
14. **SEDATIVE FILLINGS** Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
15. **SCALING AND ROOT PLANING** Limited to 1 time per quadrant per consecutive 24 months.
16. **ROOT CANAL THERAPY** Limited to 1 time per tooth per lifetime.
17. **PERIODONTAL MAINTENANCE** Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
18. **FULL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
19. **PARTIAL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
20. **RELINING AND REBASING DENTURES** Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
21. **REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES** Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
22. **PALLIATIVE TREATMENT** Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
23. **OCCLUSAL GUARDS** Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
24. **FULL MOUTH DEBRIDEMENT** Limited to 1 time every consecutive 36 months.
25. **GENERAL ANESTHESIA** Covered only when clinically necessary.
26. **OSSEOUS GRAFTS** Limited to 1 per quadrant or site per consecutive 36 months.
27. **PERIODONTAL SURGERY** Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
28. **REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR 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 consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
29. **CONE BEAM** Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
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 dental setting.
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.

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GENERAL EXCLUSIONS

15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
18. 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.
19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
20. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan Coverage unless the patient has been Covered under the Policy for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 period, the plan is responsible only for the procedures associated with the addition.
21. Replacement of missing natural teeth lost prior to the onset of plan Coverage until the patient has been Covered under the Policy for 12 continuous months.
22. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
25. 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.
26. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
27. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
28. Foreign Services are not Covered unless required as an Emergency.
29. 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.
30. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

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