UnitedHealthcare Dental®

DHMO Pismo 140/covered dental services

dental plan
D175H/D176H

ADA	DESCRIPTION	MEMBER'S COPAYMENT
DIAGNOSTIC SERVICES		
D0120	PERIODIC ORAL EVALUATION EST PT	$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$0
D0150	COMP ORAL EVALUATION - NEW/EST PT	$0
D0160	DTL&EXT ORAL EVAL - PROB FOCUS RPT	$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0210	INTRAORAL-COMPLETE SERIES	$0
D0220	INTRAORAL PERIAPICAL FIRST FILM	$0
D0230	INTRAORL PERIAPICAL EA ADD FILM	$0
D0240	INTRAORAL - OCCLUSAL FILM	$0
D0250	EXTRAORAL - FIRST FILM	$0
D0260	EXTRAORAL - EACH ADDITIONAL FILM	$0
D0270	BITEWING - SINGLE FILM	$0
D0272	BITEWINGS - TWO FILMS	$0
D0273	BITEWINGS - THREE FILMS	$0
D0274	BITEWINGS - FOUR FILMS	$0
D0277	VERTICAL BITEWINGS - 7 TO 8 FILMS	$0
D0330	PANORAMIC FILM	$0
D0415	COLLECT MICROORAGNISMS CULT & SENS	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$20
D0460	PULP VITALITY TESTS	$0
D0470	DIAGNOSTIC CASTS	$0
D0472	ACCESS TISS-GROSS EXAM-PREP & REPRT	$0
D0473	ACCESS TISS-GROSS/MICRO-PREP/REPRT	$0
D0474	ACSS TISS GR&MIC SURG MARG PREP/RPT	$0
D0999	OFFICE VISIT FEE - PER VISIT	$0
PREVENTIVE SERVICES		
D1110	PROPHYLAXIS - ADULT [1]	$0
--------	PROPHYLAXIS - ADULT [1] Add. Prophy within 6 months	$25
D1120	PROPHYLAXIS - CHILD [1]	$0
--------	PROPHYLAXIS - CHILD [1] Add. Prophy within 6 months	$25
D1203	TOP FLUORIDE - CHILD	$0
D1204	TOP FLUORIDE - ADULT	$0
D1206	TOP FLUORIDE; TX APPL MOD-HI RISK	$0
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	$0
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	$0
D1330	ORAL HYGIENE INSTRUCTIONS	$0
D1351	SEALANT - PER TOOTH	$5
D1510	SPACE MAINTAINER - FIXED-UNILATERAL	$25
D1515	SPACE MAINTAINER - FIXED-BILATERAL	$25
D1520	SPACE MAINTAINER - REMOVABLE-UNI	$35
D1525	SPACE MAINTAINER - REMOVABLE-BIL	$35
D1550	RECEMENTATION OF SPACE MAINTAINER	$5
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$10
RESTORATIVE SERVICES*		
D2140	AMALGAM-ONE SURFACE PRIMARY/PERM	$0
D2150	AMALGAM-TWO SURFACES PRIMARY/PERM	$0
D2160	AMALGAM-3 SURFACES PRIMARY/PERM	$0
D2161	AMALGAM-FOUR/MORE SURF PRIM/PERM	$0
D2330	RESIN COMPOS - ONE SURFACE ANTERIOR	$0
D2331	RESIN COMPOS - 2 SURFACES ANTERIOR	$0
D2332	RESIN COMPOS - 3 SURFACES ANTERIOR	$0

ADA	DESCRIPTION	MEMBER'S COPAYMENT
RESTORATIVE SERVICES*		
D2335	RSN COMPOS-4/> SURF/W/INCISAL ANG	$0
D2390	RESIN COMPOS CROWN ANTERIOR	$25
D2391	RESIN COMPOS - 1 SURFACE POSTERIOR	$30
D2392	RESIN COMPOS - 2 SURFACES POSTERIOR	$40
D2393	RESIN COMPOS - 3 SURFACES POSTERIOR	$55
D2394	RESIN COMPOS - 4/MORE SURFACES POST	$55
D2510	INLAY - METALLIC - ONE SURFACE	$150
D2520	INLAY - METALLIC - TWO SURFACES	$150
D2530	INLAY - METALLIC - 3/MORE SURFACES	$150
D2542	ONLAY - METALLIC - TWO SURFACES	$150
D2543	ONLAY METALLIC THREE SURFACES	$150
D2544	ONLAY METALLIC FOUR OR MORE SURF	$150
D2610	INLAY - PORCELN/CERAMIC - 1 SURFACE	$175
D2620	INLAY - PORCELN/CERAMIC - 2 SURF	$175
D2630	INLAY - PORCELN/CERAM - 3/MORE SURF	$175
D2642	ONLAY - PORCELN/CERAMIC - 2 SURF	$175
D2643	ONLAY - PORCELN/CERAMIC - 3 SURF	$175
D2644	ONLAY - PORCELN/CERAM - 4/MORE SURF	$175
D2650	INLAY-RSN COMPOS COMPOS/RSN-1 SURF	$175
D2651	INLAY-RSN COMPOS COMPOS/RSN-2 SURF	$175
D2652	INLAY-RSN COMPOS COMPOS/RSN-3/>SURF	$175
D2662	ONLAY-RSN COMPOS COMPOS/RSN-2 SURF	$175
D2663	ONLAY-RSN COMPOS COMPOS/RSN-3 SURF	$175
D2664	ONLAY-RSN COMPOS COMPOS/RSN-4/>	$175
D2710	CROWN RESINBASED COMPOSITE INDIRECT	$125
D2712	CROWN 3/4 RESNBASED COMPOS INDIRECT	$125
D2720	CROWN - RESIN WITH HIGH NOBLE METAL*	$175
D2721	CROWN - RESIN W/PREDOM BASE METAL	$175
D2722	CROWN - RESIN WITH NOBLE METAL*	$175
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$225
D2750	CROWN - PORCELN FUSED HI NOBLE METL*	$175
D2751	CROWN-PORCELN FUSD PREDOM BASE METL	$175
D2752	CROWN - PORCELAIN FUSED NOBLE METAL *	$175
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL*	$175
D2781	CROWN - 3/4 CAST PREDOM BASE METL	$175
D2782	CROWN - 3/4 CAST NOBLE METAL *	$175
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$175
D2790	CROWN - FULL CAST HIGH NOBLE METAL*	$175
D2791	CROWN - FULL CAST PREDOM BASE METL	$175
D2792	CROWN - FULL CAST NOBLE METAL *	$175
D2794	CROWN TITANIUM *	$175
D2910	RECEMENT INLAY ONLAY/PART COV REST	$0
D2915	RECEMENT CAST/PREFAB POST & CORE	$0
D2920	RECEMENT CROWN	$0
D2930	PRFABR STAINLESS STEEL CROWN-PRIM	$25
D2931	PRFABR STAINLESS STEEL CROWN-PERM	$25
D2932	PREFABRICATED RESIN CROWN	$35
D2933	PRFABR STNLSS STEEL CROWN RSN WNDOW	$35
D2940	SEDATIVE FILLING	$0
D2950	CORE BUILDUP INCLUDING ANY PINS	$25
D2951	PIN RETN - PER TOOTH ADDITION REST	$10
D2952	POST & CORE ADD CROWN INDIRECT FAB	$35
D2953	EA ADD INDIRECT FAB POST SAME TOOTH	$25

ADA	DESCRIPTION	MEMBER'S COPAYMENT
D2954	PREFABR POST&CORE ADDITION CROWN	$20
D2955	POST REMOVAL	$10
D2957	EA ADD PREFABR POST - SAME TOOTH	$30
D2970	TEMPORARY CROWN	$0
D2971	ADD PROC NEW CROWN XST PART DENTURE	$35
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$0
D3120	PULP CAP - INDIRECT	$0
D3220	TX PULPOT-CORONL DENTNOCEMENTL JUNC	$0
D3221	PULPAL DEBRID PRIMARY&PERM TEETH	$15
D3230	PULPAL THERAPY - ANT PRIMARY TOOTH	$25
D3240	PULPAL THERAPY - POST PRIMARY TOOTH	$25
D3310	ANTERIOR	$75
D3320	BICUSPID	$150
D3330	MOLAR	$275
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$85
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$65
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$65
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$100
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$170
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$295
D3351	APEXIFICAT/RECALCIFICAT - INIT VST	$65
D3352	APEXIFICAT/RECALCIFICAT-INTERIM	$65
D3353	APEXIFICAT/RECALCIFICAT-FINAL VISIT	$65
D3410	APICOECT/PERIRADICULAR SURG - ANT	$95
D3421	APICOECT/PERIRADICULR SURG-BICUSPID	$95
D3425	APICOECT/PERIRADICULAR SURG - MOLAR	$95
D3426	APICOECTOMY/PERIRADICULAR SURGERY	$55
D3430	RETROGRADE FILLING - PER ROOT	$55
D3450	ROOT AMPUTATION - PER ROOT	$95
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$15
D3920	HEMISECTION NOT INCL RC THERAPY	$90
D3950	CANAL PREP&FIT PREFORMED DOWEL/POST	$15
PERIODONTIC SERVICES		
D4210	GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	$115
D4211	GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	$75
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$140
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$85
D4245	APICALLY POSITIONED FLAP	$165
D4249	CLIN CROWN LEN - HARD TISSUE	$115
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$325
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$215
D4263	BONE REPLCMT GRAFT - 1 SITE QUAD	$175
D4264	BN REPLCMT GRAFT - EA ADD SITE QUAD	$75
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$215
D4271	FREE SOFT TISSUE GRAFT PROCEDURE	$215
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	$65
D4341	PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	$40
D4342	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	$28
D4355	FULL MOUTH DEBRID COMP EVAL&DX	$40
D4381	LOC DEL ANTIMICROBIAL AGT TOOTH BR	$35
D4910	PERIODONTAL MAINTENANCE	$30
D4920	UNSCHEDULED DRESSING CHANGE	$0
REMOVEABLE PROSTHODONTICS SERVICES*		
D5110	COMPLETE DENTURE - MAXILLARY	$225
D5120	COMPLETE DENTURE - MANDIBULAR	$225
D5130	IMMEDIATE DENTURE - MAXILLARY	$250
D5140	IMMEDIATE DENTURE - MANDIBULAR	$250

ADA	DESCRIPTION	MEMBER'S COPAYMENT
REMOVEABLE PROSTHODONTICS SERVICES*		
D5211	MAX PARTIAL DENTURE - RESIN BASE	$275
D5212	MAND PARTIAL DENTUR - RESIN BASE	$275
D5213	MAX PART DENTUR-CAST METL W/RSN	$275
D5214	MAND PART DENTUR- CAST METL W/RSN	$275
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$350
D5226	MANDIBULAR PART DENTURE FLEX BASE	$350
D5281	REMV UNI PART DENTUR-1 PC CAST METL	$260
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$0
D5411	ADJUST COMPLETE DENTUR - MANDIBULAR	$0
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$0
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$0
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	$25
D5520	REPL MISS/BROKEN TEETH-CMPL DENTUR	$25
D5610	REPAIR RESIN DENTURE BASE	$25
D5620	REPAIR CAST FRAMEWORK	$25
D5630	REPAIR OR REPLACE BROKEN CLASP	$25
D5640	REPLACE BROKEN TEETH - PER TOOTH	$25
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$25
D5660	ADD CLASP EXISTING PARTIAL DENTURE	$25
D5670	REPL ALL TEETH&ACRYLC FRMEWRK MAX	$150
D5671	REPL ALL TEETH&ACRYLC FRMEWRK MAND	$150
D5710	REBASE COMPLETE MAXILLARY DENTURE	$55
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$55
D5720	REBASE MAXILLARY PARTIAL DENTURE	$55
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$55
D5730	RELINE CMPL MAXIL DENTURE CHAIRSIDE	$35
D5731	RELINE CMPL MAND DENTURE CHAIRSIDE	$35
D5740	RELINE MAXIL PART DENTURE CHAIRSIDE	$35
D5741	RELINE MAND PART DENTURE CHAIRSIDE	$35
D5750	RELINE CMPL MAXIL DENTURE LAB	$55
D5751	RELINE CMPL MAND DENTRUE LABORATORY	$55
D5760	RELINE MAXIL PART DENTURE LAB	$55
D5761	RELINE MAND PART DENTURE LABORATORY	$55
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$55
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$55
D5850	TISSUE CONDITIONING MAXILLARY	$10
D5851	TISSUE CONDITIONING MANDIBULAR	$10
FIXED PROSTHODONTICS SERVICES*		
D6210	PONTIC - CAST HIGH NOBLE METAL*	$175
D6211	PONTIC - CAST PREDOM BASE METAL	$175
D6212	PONTIC - CAST NOBLE METAL *	$175
D6214	PONTIC TITANIUM *	$175
D6240	PONTIC-PORCELN FUSED HI NOBLE METL *	$175
D6241	PONTIC-PORCLN FUSD PREDOM BASE METL	$175
D6242	PONTIC - PORCELN FUSED NOBLE METAL *	$175
D6245	PONTIC - PORCELAIN/CERAMIC	$225
D6250	PONTIC - RESIN W/HIGH NOBLE METAL *	$175
D6251	PONTIC RESIN W/PREDOM BASE METAL	$175
D6252	PONTIC RESIN W/NOBLE METAL *	$175
D6600	INLAY-PORCELAIN/CERAMIC 2 SURFACES	$195
D6601	INLAY - PORCELN/CERAMIC 3/MORE SURF	$195
D6602	INLAY - CAST HI NOBLE METAL 2 SURF	$150
D6603	INLAY-CAST HI NOBLE METL 3/> SURF	$150
D6604	INLAY-CAST PREDOM BASE METL 2 SURF	$150
D6605	INLAY-CAST PREDOM BASE METL 3/>SURF	$150
D6606	INLAY - CAST NOBLE METAL 2 SURFACES	$150
D6607	INLAY - CAST NOBLE METL 3/MORE SURF	$150

ADA	DESCRIPTION	MEMBER'S COPAYMENT
FIXED PROSTHODONTICS SERVICES*		
D6608	ONLAY - PORCELN/CERAMIC 2 SURFACES	$205
D6609	ONLAY - PORCELN/CERAMIC 3/MORE SURF	$205
D6610	ONLAY - CAST HI NOBLE METAL 2 SURF	$150
D6611	ONLAY-CAST HI NOBLE METL 3/> SURF	$150
D6612	ONLAY-CAST PREDOM BASE METL 2 SURF	$155
D6613	ONLAY-CAST PREDOM BASE METL 3/>SURF	$155
D6614	ONLAY - CAST NOBLE METAL 2 SURFACES	$150
D6615	ONLAY - CAST NOBLE METL 3/MORE SURF	$150
D6624	INLAY TITANIUM	$175
D6634	ONLAY TITANIUM	$175
D6720	CROWN - RESIN WITH HIGH NOBLE METAL *	$175
D6721	CROWN RESIN PREDOM BASE METL-DENTUR	$175
D6722	CROWN - RESIN WITH NOBLE METAL *	$175
D6740	CROWN - PORCELAIN/CERAMIC	$225
D6750	CRWN PORCLN FUSD HI NOBL MTL-DENTUR *	$175
D6751	CROWN-PORCELN FUSD PREDOM BASE METL	$175
D6752	CROWN - PORCELAIN FUSED NOBLE METAL *	$175
D6780	CROWN - 3/4 CAST HIGH NOBLE METAL *	$175
D6781	CROWN-3/4 CAST PREDOM BASED METAL	$175
D6782	CROWN 3/4 CAST NOBLE METAL-DENTURE *	$175
D6783	CROWN 3/4 PORCELAIN/CERAMIC-DENTURE	$175
D6790	CROWN FULL CAST HI NOBL METL-DENTUR *	$175
D6791	CROWN FULL CAST BASE METAL-DENTURE	$175
D6792	CROWN FULL CAST NOBLE METAL-DENTURE *	$175
D6794	CROWN TITANIUM *	$175
D6930	RECEMENT FIXED PARTIAL DENTURE	$0
D6940	STRESS BREAKER	$115
D6970	POST&CORE ADD FIX PART DENTURE RET	$50
D6972	PRFAB POST&COR ADD PART DENTUR RETN	$30
D6973	CORE BUILD UP RETAIN INCL ANY PINS	$10
D6976	EA ADD INDIRECT FAB POST SAME TOOTH	$45
D6977	EACH ADD PRFAB POST SAME TOOTH	$45
ORAL SURGERY SERVICES		
D7111	XTRCT CORONL RMNNTS DECIDUOUS TOOTH	$0
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$0
D7210	SURG REMOVAL ERUPTED TOOTH	$25
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$50
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$75
D7240	REMOVAL IMPACTED TOOTH - CMPL BONY	$115
D7241	REMV IMP TOOTH-CMPL BNY W/SURG COMP	$135
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	$0
D7286	BIOPSY OF ORAL TISSUE SOFT	$0
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$25
D7311	ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	$10
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$40
D7321	ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	$20
D7471	REMOVAL OF LATERAL EXOSTOSIS	$75
D7472	REMOVAL OF TORUS PALATINUS	$50

ADA	DESCRIPTION	MEMBER'S COPAYMENT
ORAL SURGERY SERVICES		
D7473	REMOVAL OF TORUS MANDIBULARIS	$50
D7485	SURGICAL RDUC OSSEOUS TUBEROSITY	$50
D7510	I&D ABSCESS-INTRAORAL SOFT TISS	$25
D7511	I & D ABSC INTRAORAL SOFT TISS COMP	$25
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$25
D7960	FRENULECTOMY SEPARATE PROCEDURE	$25
D7963	FRENULOPLASTY	$25
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$35
D7971	EXCISION OF PERICORONAL GINGIVA	$30
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$100
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$10
D9211	REGIONAL BLOCK ANESTHESIA	$0
D9212	TRIGEMINAL DIVISION BLOCK ANES	$0
D9215	LOCAL ANESTHESIA	$0
D9220	DP SEDATION/GEN ANES-1ST 30 MIN	$155
D9221	DP SEDAT/GEN ANES-EA ADD 15 MIN	$75
D9241	IV CONSC SEDAT/ANALG -1ST 30 MIN	$155
D9242	IV CONSC SEDAT/ANALG-EA ADD 15 MIN	$70
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$0
D9430	OV OBS - NO OTH SERVICES PERFORMED	$5
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$35
D9450	CASE PRSATION DTL&EXT TX PLANNING	$0
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9940	OCCLUSAL GUARD BY REPORT	$85
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$30
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$80
D9972	EXTERNAL BLEACHING - PER ARCH	$125
D9999	BROKEN APPOINTMENT	$10
ORTHODONTIC SERVICES		
D8070	Comprehensive orthodontic treatment transitional dentition	$1,895
D8080	Comprehensive orthodontic treatment adolescent dentition	$1,895
D8090	Comprehensive orthodontic treatment adult dentition	$1,895
D8680	Orthodontic retention (removal of appliances, construction, and placement of retainers)	$300
D8999	Start-up fee (including exam, beginning records, x-rays, tracing, photos, and models	$250
D8999	Post Treatment Records	$150

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.

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