HealthPass℠ ANCILLARY EXCHANGE

UnitedHealthcare® Select Managed Care

Dental Select Managed Care Rates

	Four Tier
Employee	**$17.66**
Employee/Spouse	**$30.61**
Employee/Child(ren)	**$37.27**
Family	**$47.52**

About UnitedHealthcare Dental

UnitedHealthcare dental plans will help you save money and help keep your teeth and gums healthy. The health of your mouth can affect your total health. That's why it's important to have a dental plan that covers preventive care, covers hundreds of services and encourages healthy dental habits.

Plan Highlights

(In-Network only dental plan)

- No deductible
- No annual calendar maximum
- No waiting period
- 1 cleaning per consecutive 6 months
- PCD referral required to see network specialist
- Many diagnostic and preventive services are provided at no additional cost
- Reasonable copay charges apply for basic and major services
- Implant benefit
- Dependent coverage until the end of the year in which the child turns 26 years of age

The following billing and administrative fees apply to the UnitedHealthcare Select Managed Care: EE $1.50, EE/Spouse $2.25, EE+Child(ren) $2.25, Family $3.00
Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers.
Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family.
This is a summary of plan information. Please refer to the Eligibility Guidelines for further information.
The New York Select Managed Care Plan is underwritten by UnitedHealthcare Insurance Company of New York located in Islandia, New York.

ADA DESCRIPTION	MEMBER PAYS
DIAGNOSTIC SERVICES	
D0120 *PERIODIC ORAL EVALUATION EST PT	$0
D0140 LTD ORAL EVALUATION - PROBLEM FOCUS	$0
D0145 *ORAL EVAL PT<3 AND COUNSEL	$0
D0150 *COMP ORAL EVALUATION - NEW/EST PT	$0
D0160 *DTL&EXT ORAL EVAL - PROB FOCUS RPT	$0
D0170 RE-EVALUATION - LTD PROBLEM FOCUSED	$0
D0171 RE-EVALUATION – POST-OPERATIVE OFFICE VISIT	$0
D0180 *COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0210 *INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	$0
D0220 INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$4
D0230 INTRAORL PERIAPICAL EA ADD RADIOGRAPHIC IMAGE	$2
D0240 INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0
D0250 EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$0
D0251 *EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$0
D0270 *BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0
D0272 *BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0
D0273 *BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0
D0274 *BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0
D0277 *VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$30
D0310 RADIOGRAPHS -SIALOGRAPHY	$150
D0320 TMJ - Including injection	$250
D0321 RADIOGRAPHS - TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES	$150
D0322 RADIOGRAPHS OTHER TEMPOROMANDIBULAR FILMS	$150
D0330 *PANORAMIC RADIOGRAPHIC IMAGE	$50
D0340 2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$150
D0350 2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY	$20
D0364 *CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELDFIELD OF VIEW-LESS THAN ONE WHOLE JAW	$140
D0365 *CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$130
D0366 *CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$130
D0367 *CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$175
D0368 *CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$130
D0369 *MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION	$180

ADA DESCRIPTION	MEMBER PAYS
D0370 *MAXILLOFACIAL ULTRASOUND CAPTURE AND INTERPRETATION	$160
D0371 *SIALOENDOSCOPY AND CAPTURE AND INTERPRETATION	$160
D0380 *CONE BEAM CT IMAGE CAPTURE WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$140
D0381 *CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$130
D0382 *CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$130
D0383 *CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF BOTH JAWS	$175
D0384 *CONE BEAM CT IMAGE CAPTURE FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$130
D0385 *MAXILLOFACIAL MRI IMAGE CAPTURE	$160
D0386 *MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	$160
D0393 *SIMULATION USING 3D IMAGES	$0
D0394 *DIGITAL SUBTRACTION OF IMAGES	$0
D0395 *FUSION OF TWO OR MORE 3D IMAGES	$0
D0415 COLLECT MICROORAGNISMS CULT & SENS	$20
D0425 CARIES SUSCEPTIBILITY TESTS	$20
D0431 ADJUNCT PREDX TST NO CYTOL/BX PROC	$65
D0460 PULP VITALITY TESTS	$10
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
D0480 PROCESSING AND INTERP OF EXFOLIATIVE CYTOLOGICAL SMEARS, INCL PREP AND TRANS OF WRITTEN REPORT	$0
D0486 ACCESSION OF TRANSEPITHELIAL CYTOLOGIC SAMPLE, MICCROSCOPIS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0
D0502 OTHER ORAL PATHOLOGY PROCEDURES	$0
D0600 NON-IONIZING DIAGNOSTIC PROCEDURE CAPABLE OF QUANTIFYING, MONITORING, AND RECORDING CHANGES IN STRUCTURE OF ENAMEL, DENTIN AND CEMENTUM	$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

ADA DESCRIPTION	MEMBER PAYS
PREVENTIVE SERVICES	
D1110 *PROPHYLAXIS - ADULT	$0
D1110 - PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	$40
D1120 *PROPHYLAXIS - CHILD	$0
D1120 - PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6 MONTHS	$25
D1206 *TOP FLUORIDE VARNISH	$25
D1208 *TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$0
D1310 NUTRIT CNSL CONTROL DENTAL DISEASE	$0
D1320 TOBACCO CNSL CNTRL&PREVION ORL DZ	$0
D1330 ORAL HYGIENE INSTRUCTIONS	$0
D1351 *SEALANT - PER TOOTH	$0
D1352 *PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$0
D1353 SEALANT REPAIR – PER TOOTH	$0
D1354 *INTERIM CARIES ARRESTING MEDICAMENT APPLICATION	$20
D1510 *SPACE MAINTAINER - FIXED-UNILATERAL	$0
D1515 *SPACE MAINTAINER - FIXED-BILATERAL	$0
D1520 *SPACE MAINTAINER - REMOVABLE-UNI	$0
D1525 *SPACE MAINTAINER - REMOVABLE-BIL	$0
D1550 RECEMENT OR RE-BOND SPACE MAINTAINER	$25
D1555 REMOVAL OF FIXED SPACE MAINTAINER	$25
D1575 DISTAL SHOE SPACE MAINTAINER – FIXED – UNILATERAL	$0
RESTORATIVE SERVICES	
D2140 AMALGAM-ONE SURFACE PRIMARY/PERM	$0
D2150 AMALGAM-TWO SURFACES PRIMARY/PERM	$0
D2160 AMALGAM-3 SURFACES PRIMARY/PERM	$60
D2161 AMALGAM-FOUR/MORE SURF PRIM/PERM	$70
D2330 RESIN COMPOS - ONE SURFACE ANTERIOR	$45
D2331 RESIN COMPOS - 2 SURFACES ANTERIOR	$65
D2332 RESIN COMPOS - 3 SURFACES ANTERIOR	$75
D2335 RSN COMPOS-4/> SURF/W/INCISAL ANG	$88
D2390 RESIN COMPOS CROWN ANTERIOR	$125
D2391 RESIN COMPOS - 1 SURFACE POSTERIOR	$70
D2392 RESIN COMPOS - 2 SURFACES POSTERIOR	$80
D2393 RESIN COMPOS - 3 SURFACES POSTERIOR	$95
D2394 RESIN COMPOS - 4/MORE SURFACES POST	$120
D2410 GOLD FOIL - ONE SURFACE	$75
D2420 GOLD FOIL - TWO SURFACES	$95
D2430 GOLD FOIL - THREE SURFACES	$125
D2510 INLAY - METALLIC - ONE SURFACE	$290
D2520 INLAY - METALLIC - TWO SURFACES	$300
D2530 INLAY - METALLIC - 3/MORE SURFACES	$320
D2542 ONLAY - METALLIC - TWO SURFACES	$350

ADA DESCRIPTION	MEMBER PAYS
D2543 ONLAY METALLIC THREE SURFACES	$375
D2544 ONLAY METALLIC FOUR OR MORE SURF	$325
D2610 INLAY - PORCELN/CERAMIC - 1 SURFACE	$350
D2620 INLAY- PORCELN/CERAMIC - 2 SURF	$375
D2630 INLAY - PORCELN/CERAM - 3/MORE SURF	$375
D2642 ONLAY - PORCELN/CERAMIC - 2 SURF	$410
D2643 ONLAY - PORCELN/CERAMIC - 3 SURF	$440
D2644 ONLAY - PORCELN/CERAM - 4/MORE SURF	$450
D2650 INLAY-RSN COMPOS COMPOS/RSN-1 SURF	$245
D2651 INLAY-RSN COMPOS COMPOS/RSN-2 SURF	$250
D2652 INLAY-RSN COMPOS COMPOS/RSN-3/>SURF	$275
D2662 ONLAY-RSN COMPOS COMPOS/RSN-2 SURF	$245
D2663 ONLAY-RSN COMPOS COMPOS/RSN-3 SURF	$270
D2664 ONLAY-RSN COMPOS COMPOS/RSN-4/>	$285
D2710 *CROWN RESINBASED COMPOSITE INDIRECT	$195
D2712 *CROWN 3/4 RESNBASED COMPOS INDIRECT	$195
D2720 *CROWN - RESIN WITH HIGH NOBLE METAL	$450
D2721 *CROWN - RESIN W/PREDOM BASE METAL	$395
D2722 *CROWN - RESIN WITH NOBLE METAL	$420
D2740 *CROWN - PORCELAIN/CERAMIC SUBSTRATE	$525
D2750 *CROWN - PORCELN FUSED HI NOBLE METL	$495
D2751 *CROWN-PORCELN FUSD PREDOM BASE METL	$420
D2752 *CROWN - PORCELAIN FUSED NOBLE METAL	$475
D2780 *CROWN - 3/4 CAST HIGH NOBLE METAL	$425
D2781 *CROWN - 3/4 CAST PREDOM BASE METL	$405
D2782 *CROWN - 3/4 CAST NOBLE METAL	$415
D2783 *CROWN - 3/4 PORCELAIN/CERAMIC	$450
D2790 *CROWN - FULL CAST HIGH NOBLE METAL	$495
D2791 *CROWN - FULL CAST PREDOM BASE METL	$420
D2792 *CROWN - FULL CAST NOBLE METAL	$480
D2794 *CROWN TITANIUM	$470
D2799 *PROVISIONAL CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$130
D2910 RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$25
D2915 RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFAB POST & CORE	$25
D2920 RECEMENT OR RE-BOND CROWN	$25
D2921 REATTACHMENT OF TOOTH FRAGMENT	$10
D2929 PREFABRICATED PORCELAIN CROWN- PRIMARY	$34
D2930 PRFABR STAINLESS STEEL CROWN-PRIM	$0

ADA DESCRIPTION	MEMBER PAYS
D2931 PRFABR STAINLESS STEEL CROWN-PERM	$95
D2932 PREFABRICATED RESIN CROWN	$95
D2933 PRFABR STNLSS STEEL CROWN RSN WNDOW	$145
D2940 SEDATIVE FILLING	$40
D2941 INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$20
D2949 RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION	$20
D2950 CORE BUILDUP INCLUDING ANY PINS	$85
D2951 PIN RETN - PER TOOTH ADDITION REST	$20
D2952 POST & CORE ADD CROWN INDIRECT FAB	$135
D2953 EA ADD INDIRECT FAB POST SAME TOOTH	$105
D2954 PREFABR POST&CORE ADDITION CROWN	$120
D2955 POST REMOVAL	$35
D2957 EA ADD PREFABR POST - SAME TOOTH	$30
D2960 LABIAL VENEER (LAMINATE) - CHAIRSIDE	$200
D2961 LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$255
D2962 LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$425
D2971 ADD PROC NEW CROWN XST PART DENTURE	$45
D2975 COPING	$95
D2980 CROWN REPAIR	$95
D2981 INLAY REPAIR	$95
D2982 ONLAY REPAIR	$95
D2983 VENEER REPAIR	$95
D2990 RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$29
ENDODONTIC SERVICES	
D3110 PULP CAP - DIRECT	$30
D3120 PULP CAP - INDIRECT	$30
D3220 TX PULPOT-CORONL DENTNOCEMENTL JUNC	$65
D3221 PULPAL DEBRID PRIMARY&PERM TEETH	$95
D3222 PARTIAL PULPOTOMY	$75
D3230 PULPAL THERAPY - ANT PRIMARY TOOTH	$70
D3240 PULPAL THERAPY - POST PRIMARY TOOTH	$60
D3310 ANTERIOR	$310
D3320 BICUSPID	$375
D3330 MOLAR	$485
D3331 TX RC OBSTRUCTION; NON-SURG ACCESS	$85
D3332 INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$150
D3333 INTRL ROOT REPAIR PERFORATION DEFEC	$125
D3346 RETX PREVIOUS RC THERAPY - ANTERIOR	$375
D3347 RETX PREVIOUS RC THERAPY - BICUSPID	$450
D3348 RETX PREVIOUS RC THERAPY - MOLAR	$540
D3351 APEXIFICAT/RECALCIFICAT - INIT VST	$110

ADA DESCRIPTION	MEMBER PAYS
D3352 APEXIFICAT/RECALCIFICAT-INTERIM	$110
D3353 APEXIFICAT/RECALCIFICAT-FINAL VISIT	$110
D3410 APICOECTOMY SURG - ANT	$265
D3421 APICOECTOMY SURG-BICUSPID	$315
D3425 APICOECTOMY SURG - MOLAR $347	$350
D3426 APICOECTOMY SURGERY	$110
D3427 PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$265
D3428 BONE GRAFT WITH PERIRADICULAR SURGERY - PER TOOTH	$32
D3429 BONE GRAFT WITH PERIRADICULAR SURGERY - EACH ADDITIONAL TOOTH	$25
D3430 RETROGRADE FILLING - PER ROOT	$85
D3431 BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	$150
D3432 GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE	$150
D3450 ROOT AMPUTATION - PER ROOT	$195
D3460 ENDODONTIC ENDOSSEOUS IMPLANT	$535
D3470 INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING)	$175
D3910 SURG PROC ISOLAT TOOTH W/RUBBER DAM	$95
D3920 HEMISECTION NOT INCL RC THERAPY	$145
D3950 CANAL PREP&FIT PREFORMED DOWEL/POST	$75
PERIODONTIC SERVICES	
D4210 GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	$195
D4211 GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	$117
D4212 GINGIVECT/PLSTY WITH REST PROC/TOOTH	$70
D4240 GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$230
D4241 GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$222
D4245 APICALLY POSITIONED FLAP	$150
D4249 CLIN CROWN LEN - HARD TISSUE	$250
D4260 OSSEOUS SURG 4/> CNTIG TEETH QUAD	$450
D4261 OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$420
D4263 BONE REPLCMT GRAFT - 1 SITE QUAD	$450
D4264 BN REPLCMT GRAFT - EA ADD SITE QUAD	$325
D4265 BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	$325

ADA DESCRIPTION	MEMBER PAYS
D4266 GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER SITE	$325
D4267 GUIDED TISSUE REGENERATION - NONRESORBABLE BARRIER, PER SITE (INCLUDING MEMBRANE REMOVAL)	$325
D4268 SURGICAL REVISION PROCEDURE, PER TOOTH	$0
D4270 PEDICLE SOFT TISSUE GRAFT PROCEDURE	$359
D4273 AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$395
D4274 DISTAL OR PROXIMAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$135
D4275 NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$502
D4276 COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH	$65
D4277 FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$340
D4278 FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH	$75
D4283 AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	$353
D4285 NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	$392
D4320 PROVISIONAL SPLINTING - INTRACORONAL	$115
D4321 PROVISIONAL SPLINTING - EXTRACORONAL	$105
D4341 *PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	$80[t]
D4342 *PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	$60[t]
D4346 SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$60
D4355 *FULL MOUTH DEBRID COMP EVAL&DX	$60[t]
D4381 *LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$70[t]
D4910 *PERIODONTAL MAINTENANCE	$55
D4910 *ADDITIONAL PERIODONTAL MAINTENANCE	$100
D4920 UNSCHEDULED DRESSING CHANGE	$25
D4921 GINGIVAL IRRIGATION PER QUADRANT	$15
D4999 UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT	$0
REMOVABLE PROSTHODONTIC SERVICES	
D5110 *COMPLETE DENTURE - MAXILLARY	$625
D5120 *COMPLETE DENTURE - MANDIBULAR	$625

ADA DESCRIPTION	MEMBER PAYS
D5230 *IMMEDIATE DENTURE – MAXILLARY	$695
D5140 *IMMEDIATE DENTURE – MANDIBULAR	$695
D5211 *MAX PARTIAL DENTURE – RESIN BASE	$450
D5212 *MAND PARTIAL DENTUR - RESIN BASE	$450
D5213 *MAX PART DENTUR-CAST METL W/RSN	$655
D5214 *MAND PART DENTUR- CAST METL W/RSN	$655
D5221 *IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$470
D5222 *IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$470
D5223 *IMMEDIATE MAXILLARY PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$675
D5224 *IMMEDIATE MANDIBULAR PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$675
D5225 *MAXILLARY PARTIAL DENTURE FLEX BASE	$655
D5226 *MANDIBULAR PART DENTURE FLEX BASE	$655
D5281 *REMV UNI PART DENTUR-1 PC CAST METL	$255
D5410 ADJUST COMPLETE DENTURE - MAXILLARY	$20
D5411 ADJUST COMPLETE DENTUR - MANDIBULAR	$20
D5421 ADJUST PARTIAL DENTURE - MAXILLARY	$20
D5422 ADJUST PARTIAL DENTURE - MANDIBULAR	$20
D5511 *REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	$75
D5512 *REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	$75
D5520 *REPL MISS/BROKEN TEETH-CMPL DENTUR	$70
D5611 *REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	$50
D5612 *REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	$50
D5621 *REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	$55
D5622 *REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	$55
D5630 *REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$55
D5640 *REPLACE BROKEN TEETH - PER TOOTH	$45
D5650 *ADD TOOTH EXISTING PARTIAL DENTURE	$65
D5660 *ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$75
D5670 *REPL ALL TEETH&ACRYLC FRMEWRK MAX	$220
D5671 *REPL ALL TEETH&ACRYLC FRMEWRK MAND	$220
D5710 *REBASE COMPLETE MAXILLARY DENTURE	$195
D5711 *REBASE COMPLETE MANDIBULAR DENTURE	$195
D5720 *REBASE MAXILLARY PARTIAL DENTURE	$175
D5721 *REBASE MANDIBULAR PARTIAL DENTURE	$175
D5730 *RELINE CMPL MAXIL DENTURE CHAIRSIDE	$85
D5731 *RELINE CMPL MAND DENTURE CHAIRSIDE	$85
D5740 *RELINE MAXIL PART DENTURE CHAIRSIDE	$65
D5741 *RELINE MAND PART DENTURE CHAIRSIDE	$65
D5750 *RELINE CMPL MAXIL DENTURE LAB	$150

ADA DESCRIPTION	MEMBER PAYS
D5751 *RELINE CMPL MAND DENTRUE LABORATORY	$150
D5760 *RELINE MAXIL PART DENTURE LAB	$110
D5761 PROSTHESIS: ENDOSTEAL IMPLANT	$110
D5810 *INTERIM COMPLETE DENTURE (MAXILLARY)	$250
D5811 *INTERIM COMPLETE DENTURE (MANDIBULAR)	$250
D5820 *INTERIM PARTIAL DENTURE MAXILLARY	$250
D5821 *INTERIM PARTIAL DENTURE MANDIBULAR	$250
D5850 TISSUE CONDITIONING MAXILLARY	$55
D5851 TISSUE CONDITIONING MANDIBULAR	$55
D5862 PRECISION ATTACHMENT, BY REPORT	$150
D5899 UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT	$0
D5982 SURGICAL STENT	$325
D5987 COMMISSURE SPLINT	$325
D5988 SURGICAL SPLINT	$325
IMPLANT SERVICES	
D6010 *SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,100
D6012 *SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL	$1,100
D6056 *PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$20
D6057 *CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$640
D6058 *ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$840
D6059 *ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$840
D6060 *ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$840
D6061 *ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$840
D6062 *ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$840
D6063 *ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$840
D6064 *ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$840
D6065 *IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$840
D6066 *IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN	$840
D6067 *IMPLANT SUPPORTED METAL CROWN	$840
D6068 *ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$840
D6069 *ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$840
D6070 *ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$840

ADA DESCRIPTION	MEMBER PAYS
D6071 *ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$840
D6072 *ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$840
D6073 *ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$840
D6074 *ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$840
D6075 *IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$840
D6076 *IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD	$840
D6077 *IMPLANT SUPPORTED RETAINER FOR CASE METAL FPD	$840
D6080 IMPLANT MAINTENANCE	$180
D6090 REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	
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	$80[t]
D6085 PROVISIONAL IMPLANT CROWN	$125
D6090 REPAIR IMPLANT SUPPORTED PROTHESIS, BY REPORT	$400
D6092 RECEMENT IMPLANT/ABUTMENT CROWN	$45
D6093 RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$65
D6094 *ABUTMENT SUPPORTED CROWN – TITANIUM	$840
D6095 REPAIR IMPLANT ABUTMENT, BY REPORT	$220
D6096 REMOVE BROKEN IMPLANT RETAINING SCREW	$500
D6100 IMPLANT REMOVAL, BY REPORT	$700
D6110 *IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$1,345
D6111 *IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$1,345
D6112 *IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$1,085
D6113 *IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$1,085
D6114 *IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH– MAXILLARY	$3,945
D6115 *IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH– MANDIBULAR	$3,945
D6116 *IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$2,345
D6117 *IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$2,345
D6118 *IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR ENDENTULOUS ARCH – MANDIBULAR	$1,876

ADA DESCRIPTION	MEMBER PAYS
D6119 *IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR ENDENTULOUS ARCH – MAXILLARY	$1,876
FIXED PROSTHODONTIC SERVICES	
D6205 *PONTIC- INDIRECT RESIN BASED COMPOSITE	$695
D6210 *PONTIC - CAST HIGH NOBLE METAL	$495
D6211 *PONTIC - CAST PREDOM BASE METAL	$420
D6212 *PONTIC - CAST NOBLE METAL	$475
D6214 *PONTIC TITANIUM	$475
D6240 *PONTIC-PORCELN FUSED HI NOBLE METL	$495
D6241 *PONTIC-PORCLN FUSD PREDOM BASE METL	$420
D6242 *PONTIC - PORCELN FUSED NOBLE METAL	$475
D6245 *PONTIC - PORCELAIN/CERAMIC	$495
D6250 *PONTIC - RESIN W/HIGH NOBLE METAL	$455
D6251 *PONTIC RESIN W/PREDOM BASE METAL	$405
D6252 *PONTIC RESIN W/NOBLE METAL	$420
D6253 *PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$0
D6545 RETAINER- CASE MTL FOR RESIN FXD PROS	$180
D6548 RET-PORC/CER FOR RESIN BONDED FIXED PROS	$495
D6600 RETAINER INLAY-PORCELAIN/CERAMIC 2 SURFACES	$495
D6601 RETAINER INLAY - PORCELN/CERAMIC 3/MORE SURF	$495
D6602 RETAINER INLAY - CAST HI NOBLE METAL 2 SURF	$425
D6603 RETAINER INLAY-CAST HI NOBLE METL 3/> SURF	$425
D6604 RETAINER INLAY-CAST PREDOM BASE METL 2 SURF	$405
D6605 RETAINER INLAY-CAST PREDOM BASE METL 3/>SURF	$405
D6606 RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$420
D6607 RETAINER INLAY - CAST NOBLE METL 3/MORE SURF	$420
D6608 RETAINER ONLAY - PORCELN/CERAMIC 2 SURFACES	$495
D6609 RETAINER ONLAY - PORCELN/CERAMIC 3/MORE SURF	$495
D6610 RETAINER ONLAY - CAST HI NOBLE METAL 2 SURF	$425
D6611 RETAINER ONLAY-CAST HI NOBLE METL 3/> SURF	$475
D6612 RETAINER ONLAY-CAST PREDOM BASE METL 2 SURF	$405
D6613 RETAINER ONLAY-CAST PREDOM BASE METL 3/>SURF	$405
D6614 RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$420
D6615 RETAINER ONLAY - CAST NOBLE METL 3/MORE SURF	$420
D6624 RETAINER INLAY - TITANIUM	$495
D6634 RETAINER ONLAY - TITANIUM	$420
D6710 *RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$195
D6720 *RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$455
D6721 *RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$405
D6722 *RETAINER CROWN - RESIN WITH NOBLE METAL	$420
D6740 *RETAINER CROWN - PORCELAIN/CERAMIC	$495

ADA DESCRIPTION	MEMBER PAYS
D6750 *RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$495
D6751 *RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$420
D6752 *RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$475
D6780 *RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$425
D6781 *RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$405
D6782 *RETAINER CROWN - 3/4 CAST NOBLE METAL	$415
D6783 *RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$405
D6790 *RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$310
D6791 *RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$420
D6792 *RETAINER CROWN - FULL CAST NOBLE METAL	$475
D6793 *PROVISIONAL RETAINER CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$130
D6794 RETAINER CROWN - TITANIUM	$250
D6930 RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$40
D6940 STRESS BREAKER	$125
D6950 PRECISION ATTACHMENT	$195
D6980 FIXED PARTIAL DENTURE REPAIR, BY REPORT	$80
ORAL SURGERY SERVICES	
D7111 XTRCT CORONL RMNNTS DECIDUOUS TOOTH	$70
D7140 EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$75
D7210 EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$120
D7220 REMOVAL IMPACT TOOTH - SOFT TISSUE	$125
D7230 REMOVAL IMPACT TOOTH - PARTLY BONY	$140
D7240 REMOVAL IMPACTED TOOTH - CMPL BONY	$160
D7241 REMV IMP TOOTH-CMPL BNY W/SURG COMP	$180
D7250 REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$95
D7251 CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	$270
D7260 OROANTRAL FISTULA CLOSURE	$160
D7261 PRIMARY CLOSURE OF A SINUS PERFORATION	$275
D7270 TOOTH REIMPL&/STBL ACC DISPLCD	$50
D7272 TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)	$100
D7280 SURGICAL ACCESS AN UNERUPTED TOOTH	$125
D7282 MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	$125
D7283 PLACEMENT DEVICE FACILITATE ERUPT IMPACTED TOOTH	$80

ADA DESCRIPTION	MEMBER PAYS
D7285 INCISIONAL BIOPSY OF ORAL TISSUE HARD	$150
D7286 INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$95
D7287 EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$85
D7288 BRUSH BIOPSY	$25
D7291 TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	$95
D7310 ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$95
D7311 ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	$95
D7320 ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$190
D7321 ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	$190
D7340 VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$370
D7350 VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$990
D7410 EXCISION OF BENIGN LESION UP TO 1.25 CM	$25
D7411 EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	$50
D7412 EXCISION OF BENIGN LESION, COMPLICATED	$55
D7450 REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$65
D7471 REMOVAL OF LATERAL EXOSTOSIS	$95
D7472 REMOVAL OF TORUS PALATINUS	$95
D7473 REMOVAL OF TORUS MANDIBULARIS	$95
D7485 SURGICAL RDUC OSSEOUS TUBEROSITY	$95
D7510 I&D ABSCESS-INTRAORAL SOFT TISS	$55
D7511 I & D ABSC INTRAORAL SOFT TISS COMP	$20
D7520 I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$20
D7521 I & D OF ABSCESS EXTRAORAL COMPLICATED	$20
D7910 SUTURE RECENT SMALL WOUNDS UP 5 CM	$35
D7921 COLLECTION AND APPLICATION OF AUTOLOGOUS BLOOD CONCENTRATE PRODUCT	$125
D7950 OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES - AUTOGENOUS OR NONAUTOGENOUS, BY REPORT	$350
D7951 SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES VIA A LATERAL OPEN APPROACH	$800
D7952 SINUS AUGMENTATION VIA A VERTICAL APPROACH	$350
D7953 BONE REPLACEMENT GRAFT FOR RIDGE PERSERVATION	$100
D7960 FRENULECTOMY	$110
D7963 FRENULOPLASTY	$110
D7970 EXC HYPERPLASTIC TISSUE-PER ARCH	$140
D7971 EXCISION OF PERICORONAL GINGIVA	$102
D7972 SURGICAL RDUC FIBROUS TUBEROSITY	$125

ADA DESCRIPTION	MEMBER PAYS
ADJUNCTIVE GENERAL SERVICES	
D9110 PALLIATVE TX DENTAL PAIN-MINOR PROC	$0
D9120 FIXED PARTIAL DENTURE SECTIONING	$0
D9210 LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$0
D9211 REGIONAL BLOCK ANESTHESIA	$0
D9212 TRIGEMINAL DIVISION BLOCK ANES	$0
D9215 LOCAL ANESTHESIA	$0
D9222 DEEP SEDATION/GENERAL ANESTHESIA – FIRST 15 MINUTES	$50
D9223 DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$50
D9230 ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$20
D9239 INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA- FIRST 15 MINUTES	$65
D9243 INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$65
D9248 NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$15
D9310 CNSLT DX DENT/PHY NOT REQ DENT/PHY	$25
D9430 OV OBS - NO OTH SERVICES PERFORMED	$5
D9440 OV-AFTER REGULARLY SCHEDULED HRS	$35
D9450 CASE PRSATION DTL&EXT TX PLANNING	$0
D9610 THERAPEUTIC DRUG INJECTION, BY REPORT	$15
D9630 DRUGS OR MEDICAMENTS DISPENSED IN THE OFFICE FOR HOME USE	$15
D9910 *APPLICATION OF DESENSITIZING MEDICAMENT	$20
D9930 TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9932 CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MAXILLARY	$0
D9933 CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MANBIBULAR	$0
D9934 CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MAXILLARY $0	$0
D9935 CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MANDIBULAR $0	$0
D9940 *OCCLUSAL GUARD BY REPORT	$250
D9942 REPAIR AND/OR RELINE OCCCLUSAL GUARDS	$40
D9943 OCCLUSAL GUARD ADJUSTMENT	$25
D9950 OCCLUSAL ANALYSIS - MOUNTED CASE	$75
D9951 OCCLUSAL ADJUSTMENT - LIMITED	$30
D9952 OCCLUSAL ADJUSTMENT - COMPLETE	$125
D9973 EXTERNAL BLEACHING-PER TOOTH	$30
D9975 EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	$240
D9986 MISSED APPOINTMENT	$25

ADA DESCRIPTION	MEMBER PAYS
D9991 DENTAL CASE MANAGEMENT - ADDRESSING APPOINTMENT	$0
D9992 DENTAL CASE MANAGEMENT – CARE COORDINATION	$0
D9993 DENTAL CASE MANAGEMENT – MOTIVATIONAL INTERVIEWING	$0
D9994 DENTAL CASE MANAGEMENT – PATIENT EDUCATION TO IMPROVE ORAL HEALTH LITERACY	$0

SPECIALTY SERVICES

a) This Member Schedule of Benefits applies when listed dental services are performed by a participating General Dentist, unless otherwise authorized.

b) Procedures not listed on the Schedule of Benefits that are performed by a participating General Dentist will be charged at a participating General Dentist's usual and customary fee less 25%.

c) The Network General Dentist you select may not perform all procedures listed. The Co-payment shown apply to Network General Dentist.

d) Should the services of a Network Specialty Dentist (NSD) (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist) be necessary, you may go directly to a NSD with no referral and receive a 25% reduction off the provider's Usual and Customary Fee.

e) Members seeking implant treatment should refer to their participating implantologist, a select Network of Participating Providers. Not all providers perform the implant procedures at the Co-payment listed on the Schedule of Benefits. Please refer to the provider listing at www.MyUHC.com.

LIMITATIONS:

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1. **COMPLETE SERIES OR PANOREX RADIOGRAPHS –** Either D0210 or D0330 are reimbursable one (1) time every five (5) consecutive years.
2. **RADIOGRAPHS –** D0364-D0365 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.
3. **BITEWING RADIOGRAPHS -** D0274, D0277 or D0210 are payable only when other inclusive image have not been taken (paid) within the last six (6) months. All Bitewing X-rays are limited to one set in any twelve (12) consecutive month period.
4. **X-RAYS -** Copies of X-rays can be obtained for $2 per periapical image up to a maximum of $30. Panoramic X-ray can be obtained for a $15 fee.
5. **FLUORIDE TREATMENT -** Fluoride treatment is limited to one (1) in any twelve (12) consecutive month period for children under the age of 16

6. SPACE MAINTAINERS - Space maintainers and all adjustments are limited to children under the age of 16.

7. **SEALANTS -** Sealants (D1351 or D1352) are limited to one (1) time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.
8. **OCCLUSAL GUARDS -** Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
9. **GENERAL ANESTHESIA -** General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary, and previously approved.
10. **ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS** – All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are included as part of the initial insertion.
11. **ORAL EVALUATION –** Any oral evaluation (excluding problem) is limited to One (1) time per consecutive six (6) months; Comprehensive exams can only be covered one (1) time per 36 months, if and only if patient is considered to be new or an established patient. All subsequent oral evaluations will be at a 25% reduction off the dentist's usual and customary fee without a frequency limitation.
12. **CROWNS, FIXED BRIDGES AND IMPLANTS -** When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of $30.00 per unit.
13. **THIRD-MOLAR ("WISDOM TEETH") EXTRACTIONS -** Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.
14. **PROPHYLAXIS AND PERIODONTAL MAINTENANCE -** The dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive six (6) month period. Any additional procedures will follow D1110 and D4910 Member copayments as listed in the Schedule of Benefits.
15. **HARMFUL HABIT APPLIANCES -** Harmful habit appliances are limited to one (1) time per person under the age of 16.
16. **DENTURES -** New dentures include one (1) reline within the first six (6) months.
17. **REPLACEMENT OF CROWNS, IMPLANTS, AND FIXED BRIDGES OR DENTURES -** Replacement of crowns, implants, and fixed bridges or dentures is limited to one (1) time every consecutive five (5) years.
18. **COST OF MATERIAL AND LAB FEES -** Copayments marked by '*' do not include the cost of material and laboratory fees. Additional cost to patient is as follows: - High noble metal (precious) up to $145.00- Titanium metal up to $120 (covered with proof of allergy to other metals)- Noble metal (semi-precious) up to $120.00- Predominantly base metal (non-precious) up to $55.00- Crown laboratory fees up to $155.00- Laboratory fees on dentures up to $225.00- Porcelain laboratory fees for D2610-D2644, D2929, D2961, D2962, D6600, D6601, D6608, and D6609 up to $65.00- Denture repair laboratory fees up to $50.00- All ceramic and/or porcelain crown material fees up to $155.00.
19. **EMERGENCY TREATMENT -** Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1. Dental Services that are not Necessary.
2. 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. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
9. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
10. 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.
11. 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.
12. 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.
13. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
14. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
15. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
16. 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. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

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. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
18. Occlusal guards used as a safety item or to affect performance primarily in sports-related activities.
19. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
20. 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.
21. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
22. Orthodontic Services
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. 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.