UnitedHealthcare®

Select Managed Care Direct Compensation Contributory CA230/covered dental services

Dental Plan
CA D1063

ADA	DESCRIPTION	MEMBER'S COPAYMENT
DIAGNOSTIC SERVICES		
D0120	PERIODIC ORAL EVAL ESTABLISHED PATIENT	$0
D0140	LIMITED ORAL EVAL - PROBLEM FOCUSED	$0
D0145	ORAL EVAL PATIENT <3 AND COUNSEL WITH PRIMARY CARE GIVER	$0
D0150	COMPREHENSIVE ORAL EVAL - NEW/ESTABLISHED PATIENT	$0
D0160	DETAILED & EXTENSIVE ORAL EVAL - PROBLEM FOCUSED REPRT	$0
D0170	RE-EVAL - LIMITED PROBLEM FOCUSED	$0
D0180	COMPREHENSIVE PERIODONTAL EVAL - NEW/ESTABLISHED PATIENT	$0
D0190	SCREENING OF A PATIENT	$5
D0191	ASSESSMENT OF A PATIENT	$5
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	$0
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$0
D0230	INTRAORAL - PERIAPICAL EACH ADDL RADIOGRAPHIC IMAGE	$0
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0
D0250	EXTRAORAL - FIRST RADIOGRAPHIC IMAGE	$0
D0260	EXTRAORAL - EACH ADDITIONAL RADIOGRAPHIC IMAGE	$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$0
D0290	POST-ANTERIOR LATERAL SKULL & FACIAL RADIOGRAPHIC IMAGE	$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$0
D0340	CEPHALOMETRIC RADIOGRAPH IMAGE	$10
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	$5
D0415	COLLECT MICROORGANISMS CULTURE & SENSITIVITY	$0
D0416	VIRAL CULTURE	$0
D0417	COLLECTION & PREPARATION OF SALIVA SAMPLE	$0
D0418	ANALYSIS OF SALIVA SAMPLE	$0
D0421	GENETIC TEST FOR SUSCEPTIBILITY TO ORAL DISEASES	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCTIVE PREDIAGNOSTIC TEST	$0
D0460	PULP VITALITY TESTS	$0
D0470	DIAGNOSTIC CASTS	$0
D0472	ACCESSION OF TISSUE-GROSS EXAM, PREP & REPRT	$0
D0473	ACCESSION OF TISSUE-GROSS/MICRO EXAM PREP & REPRT	$0
D0474	ACCESSION OF TISSUE-MICRO GROSS/MICRO EXAM, INCLD ASSESS MARGIN FOR DISEASE, PREP & REPRT	$0
D0601	CARIES RISK ASSESS & DOCUMENT W/FIND LOW RISK	$0
D0602	CARIES RISK ASSESS & DOCUMENT W/FIND MODERATE RISK	$0
D0603	CARIES RISK ASSESS & DOCUMENT W/FIND HIGH RISK	$0
PREVENTIVE SERVICES		
D1110	PROPHYLAXIS - ADULT	$0
D1120	PROPHYLAXIS - CHILD	$0
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	$0
D1208	TOPICAL APPLICATION OF FLUORIDE	$0
D1310	NUTRITIONAL COUNSELING CONTROL DENTAL DISEASE	$0
D1320	TOBACCO COUNSELING CONTROL & PREV ORAL DISEASE	$0
D1330	ORAL HYGIENE INSTRUCTIONS	$0
D1351	SEALANT - PER TOOTH	$0
D1352	PREV RESIN RESTORATION MOD HIGH CARIES RISK PATIENT	$0
D1510	SPACE MAINTAINER - FIXED-UNILATERAL	$0
D1515	SPACE MAINTAINER - FIXED-BILATERAL	$0
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL	$0
D1525	SPACE MAINTAINER - REMOVABLE-BILATERAL	$0
D1550	RECEMENTATION OF SPACE MAINTAINER	$0
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$0
RESTORATIVE SERVICES		
D2140	AMALGAM - 1 SURFACE PRIMARY/PERMANENT	$10
D2150	AMALGAM- 2 SURFACES PRIMARY/PERMANENT	$15
D2160	AMALGAM - 3 SURFACES PRIMARY/PERMANENT	$20
D2161	AMALGAM - 4/> SURFACES PRIMARY/PERMANENT	$20
D2330	RESIN-BASED COMPOSITE - 1 SURFACE, ANTERIOR	$10
D2331	RESIN COMPOSITE - 2 SURFACES, ANTERIOR	$15
D2332	RESIN COMPOSITE - 3 SURFACES, ANTERIOR	$20
D2335	RESIN COMPOSITE - 4/> SURFACES/W/INCISAL ANG	$20
D2390	RESIN COMPOSITE CROWN ANTERIOR	$20
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	$15
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	$20
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	$30
D2394	RESIN COMPOSITE- 4/MORE SURFACES POST	$30
D2510	INLAY - METALLIC - 1 SURFACE	$115
D2520	INLAY - METALLIC - 2 SURFACES	$115
D2530	INLAY - METALLIC - 3/> SURFACES	$115
D2542	ONLAY - METALLIC - 2 SURFACES	$115
D2543	ONLAY - METALLIC - 3 SURFACES	$115
D2544	ONLAY - METALLIC 4/> SURFACES	$115
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	$40
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$45
D2630	INLAY - PORCELAIN/CERAMIC - 3/> SURFACES	$55
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$115
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	$115
D2644	ONLAY - PORCELAIN/CERAMIC - 4/> SURFACES	$115
D2650	INLAY - RESIN BASED COMPOSITE -1 SURFACE	$35
D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	$40
D2652	INLAY - RESIN BASED COMPOSITE - 3/> SURFACES	$45
D2662	ONLAY - RESIN BASED COMPOSITE -2 SURFACES	$35
D2663	ONLAY - RESIN BASED COMPOSITE -3 SURFACES	$45
D2664	ONLAY - RESIN BASED COMPOSITE - 4/> SURFACES	$55
D2710	CROWN - RESIN BASED COMPOSITE INDIRECT	$25
D2712	CROWN - 3/4 RESIN BASED COMPOSITE INDIRECT	$25
D2720	CROWN - RESIN WITH HIGH NOBLE METAL*	$45
D2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	$35
D2722	CROWN - RESIN WITH NOBLE METAL*	$40
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$120
D2750	CROWN - PORCELAIN FUSED HIGH NOBLE METAL*	$120
D2751	CROWN - PORCELAIN FUSED PREDOMINANTLY BASE METAL	$110
D2752	CROWN - PORCELAIN FUSED NOBLE METAL*	$120
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL*	$115
D2781	CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$110
D2782	CROWN - 3/4 CAST NOBLE METAL *	$115

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D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$115
D2790	CROWN - FULL CAST HIGH NOBLE METAL*	$120
D2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	$110
D2792	CROWN - FULL CAST NOBLE METAL *	$120
D2794	CROWN TITANIUM*	$120
D2910	RECEMENT INLAY, ONLAY/PARTIAL COVERAGE RESTOR	$5
D2915	RECEMENT CAST/PREFABRICATED POST & CORE	$5
D2920	RECEMENT CROWN	$5
D2921	REATTACH TOOTH FRAGMENT, INCISAL EDGE OR CUSP	$5
D2929	PREFABRIC PORCELAIN/CERAMIC CROWN-PRIMARY-TOOTH	$10
D2930	PREFARBICATED STAINLESS STEEL CROWN - PRIMARY	$10
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	$15
D2932	PREFABRICATED RESIN CROWN	$10
D2933	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	$10
D2934	PREFABRIC ESTHTC COAT STNLS STL CRWN-PRIMARY TOOTH	$10
D2940	PROTECTIVE RESTORATION	$5
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$5
D2950	CORE BUILD-UP, INCLUDING ANY PINS	$5
D2951	PIN RETENTION - PER TOOTH ADDITION RESTORATION	$5
D2952	POST & CORE ADDITION CROWN INDIRECT FABRICATED	$30
D2953	EACH ADDL INDIRECTLY FABRICATED POST - SAME TOOTH	$5
D2954	PREFABRICATED POST & CORE ADDITION CROWN	$15
D2955	POST REMOVAL	$25
D2957	EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH	$5
D2960	LABIAL VENEER (RESIN BASED) - CHAIRSIDE	$25
D2961	LABIAL VENEER (RESIN BASED) - LABORATORY	$45
D2962	LABIAL VENEER (PORCELAIN LAMINATE)	$45
D2970	TEMPORARY CROWN	$15
D2971	ADDL PROCEDURE NEW CROWN EXIST PARTIAL DENTURE	$15
D2975	COPING	$85
D2980	CROWN REPAIR	$20
D2990	RESIN INFILTRATION INCIPIENT SMTH SURFACE LESIONS	$5
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$5
D3120	PULP CAP - INDIRECT	$0
D3220	THERAPEUTIC PULPOTOMY	$5
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMANENT TEETH	$5
D3222	PARTIAL PULPTOMY FOR APEXOGENESIS PERMANENT TOOTH	$5
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$5
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$5
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH	$40
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH	$75
D3330	ENDODONTIC THERAPY, MOLAR	$100
D3331	TREATMENT ROOT CANAL OBSTRUCTION; NON-SURG ACCESS	$5
D3332	INCOMPLETED ENDODONTIC THERAPY	$5
D3333	INTERNAL ROOT REPAIR PERFORATION DEFECTS	$15
D3346	RETREATMENT PREV ROOT CANAL THERAPY - ANTERIOR	$40
D3347	RETREATMENT PREV ROOT CANAL THERAPY - BICUSPID	$55
D3348	RETREATMENT PREV ROOT CANAL THERAPY - MOLAR	$95
D3351	APEXIFICATION/RECALCIFICATION INITIAL VISIT	$10
D3352	APEXIFICATION/RECALCIFICATION INTERIM MEDICATION REPLACEMENT	$10
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$20
D3355	PULPAL REGENERATION - INITIAL VISIT	$10
D3356	PULPAL REGENERATION -INTERIM MEDICAMENT REPLACEMNT	$10
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	$20
D3410	APICOECTOMY - ANTERIOR	$35
D3421	APICOECTOMY - BICUSPID	$55
D3425	APICOECTOMY - MOLAR	$80
D3426	APICOECTOMY - EACH ADDITIONAL ROOT	$25
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$25
D3430	RETROGRADE FILLING - PER ROOT	$25
D3450	ROOT AMPUTATION - PER ROOT	$20
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$1950
D3910	SURGICAL PROCED ISOLATION TOOTH W/RUBBER DAM	$10
D3920	HEMISECTION NOT INCLUDIING ROOT CANAL THERAPY	$15
D3950	CANAL PREPARATION & FIT PREFORMED DOWEL/POST	$15
PERIODONTIC SERVICES		
D4210	GINGIVECTOMY/GINGIVOPLASTY 4/> CNTIG TEETH QUAD	$25
D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	$10
D4212	GINGIVECTOMY/GINGIVOPLASTY ALLOW ACCESS RESTOR PROC, PER TOOTH	$5
D4240	GINGIVAL FLAP - 4/>CNTIG/BOUND TEETH QUAD	$25
D4241	GINGIVAL FLAP - 1-3 CNTIG/BOUND TEETH QUAD	$15
D4245	APICALLY POSITIONED FLAP	$25
D4249	CLINICAL CROWN LENGTHENING - HARD TISSUE	$25
D4260	OSSEOUS SURGERY - 4/> CONTIGUOUS TEETH QUAD	$80
D4261	OSSEOUS SURGERY - 1-3 CONTIGUOUS TEETH QUAD	$50
D4263	BONE REPLACEMENT GRAFT - 1 SITE QUAD	$40
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$25
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE - SEPARATE PROCEDURE	$25
D4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLD DONOR SITE SURGERY), FIRST TOOTH	$30
D4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLD DONOR SITE SURGERY), EACH ADDL; CONTIGUOUS TOOTH	$15
D4320	PROVISONAL SPLINTING - INTRACORONAL	$25
D4321	PROVISONAL SPLINTING - EXTRACORONAL	$20
D4341	PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD	$40
D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	$25
D4355	FULL MOUTH DEBRIDEMENT COMP EVAL & DIAGNOSIS	$15
D4381	LOCAL DELIVERY ANTIMICROBIAL AGENT PER TOOTH	$5
D4910	PERIODONTAL MAINTENANCE	$10
D4920	UNSCHEDULED DRESSING CHANGE	$5
D4921	GINGIVAL IRRIGATION - PER QUADRANT	$0
REMOVABLE PROSTHODONTICS SERVICES		
D5110	COMPLETE DENTURE - MAXILLARY	$170
D5120	COMPLETE DENTURE - MANDIBULAR	$170
D5130	IMMEDIATE DENTURE - MAXILLARY	$170
D5140	IMMEDIATE DENTURE - MANDIBULAR	$170
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	$45
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$45
D5213	MAXILLARY PARTIAL DENTURE -CAST METAL W/RESIN	$170
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL W/RESIN	$170
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$50
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	$50
D5281	REMOVAL UNILATERAL PARTIAL DENTURE -1 PC CAST METAL	$25
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$5
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$5
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$5
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$5

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D5510	REPAIR BROKEN COMPLETE DENTURE BASE	$15
D5520	REPLACE MISSING/BROKEN TEETH-COMPLETE DENTURE	$10
D5610	REPAIR RESIN DENTURE BASE	$15
D5620	REPAIR CAST FRAMEWORK	$30
D5630	REPAIR OR REPLACE BROKEN CLASP	$30
D5640	REPLACE BROKEN TEETH - PER TOOTH	$15
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$15
D5660	ADD CLASP EXISTING PARTIAL DENTURE	$25
D5670	REPLACE ALL TEETH & ACRYLIC FRAMEWORK MAXILLARY	$55
D5671	REPLACE ALL TEETH & ACRYLIC FRAMEWORK MANDIBULAR	$55
D5710	REBASE COMPLETE MAXILLARY DENTURE	$45
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$45
D5720	REBASE MAXILLARY PARTIAL DENTURE	$40
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$40
D5730	RELINE COMPLETE MAXILLARY DENTURE CHAIRSIDE	$25
D5731	RELINE COMPLETE MANDIBULAR DENTURE CHAIRSIDE	$25
D5740	RELINE MAXILLARY PARTIAL DENTURE CHAIRSIDE	$25
D5741	RELINE MANDIBULAR PARTIAL DENTURE CHAIRSIDE	$25
D5750	RELINE COMPLETE MAXILLARY DENTURE LABORATORY	$35
D5751	RELINE COMPLETE MANDIBULAR DENTURE LABORATORY	$35
D5760	RELINE MAXILLARY PARTIAL DENTURE LABORATORY	$35
D5761	RELINE MANDIBULAR PARTIAL DENTURE LABORATORY	$35
D5810	INTERIM COMPLETE DENTURE MAXILLARY	$45
D5811	INTERIM COMPLETE DENTURE MANDIBULAR	$45
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$35
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$35
D5850	TISSUE CONDITIONING MAXILLARY	$10
D5851	TISSUE CONDITIONING MANDIBULAR	$10
D5863	OVERDENTURE - COMPLETE MAXILLARY	$170
D5864	OVERDENTURE - PARTIAL MAXILLARY	$170
D5865	OVERDENTURE - COMPLETE MANDIBULAR	$170
D5866	OVERDENTURE - PARTIAL MANDIBULAR	$170
D5992	ADJUST MAXILLOFACIAL PROSTH APPLIANCE, BY REPORT	$5
FIXED PROSTHODONTICS SERVICES		
D6205	PONTIC - INDIRECT RESIN BASED COMPOSITE	$25
D6210	PONTIC - CAST HIGH NOBLE METAL*	$95
D6211	PONTIC - CAST PREDOMINANTLY BASE METAL	$90
D6212	PONTIC - CAST NOBLE METAL*	$95
D6214	PONTIC - TITANIUM*	$95
D6240	PONTIC - PORCELAIN FUSED HIGH NOBLE METAL*	$95
D6241	PONTIC - PORCELAIN FUSED PREDOMINANTLY BASE METAL	$90
D6242	PONTIC - PORCELAIN FUSED NOBLE METAL*	$95
D6245	PONTIC - PORCELAIN/CERAMIC	$115
D6250	PONTIC - RESIN W/HIGH NOBLE METAL*	$30
D6251	PONTIC - RESIN W/PREDOMINANTLY BASE METAL	$15
D6252	PONTIC - RESIN W/NOBLE METAL*	$20
D6253	PROVISIONAL PONTIC	$30
D6545	RETAINER-CAST METAL, RESIN, BOND FIXED PROSTHETIC	$15
D6548	RETAINER-PORCELAIN/CERAMIC, RESN BOND FIXED PROSTHETIC	$15
D6600	INLAY - PORCELAIN/CERAMIC 2 SURFACES	$45
D6601	INLAY - PORCELAIN/CERAMIC 3/> SURFACES	$55
D6602	INLAY - CAST HIGH NOBLE METAL 2 SURFACES*	$45
D6603	INLAY - CAST HIGH NOBLE METAL 3/> SURFACES*	$55
D6604	INLAY - CAST PREDOMINANTLY BASE METAL 2 SURFACES	$45
D6605	INLAY - CAST PREDOMINANTLY BASE METAL 3/>SURFACES	$55
D6606	INLAY - CAST NOBLE METAL 2 SURFACES*	$45
D6607	INLAY - CAST NOBLE METAL 3/> SURFACES*	$55
D6608	ONLAY - PORCELAIN/CERAMIC 2 SURFACES	$55
D6609	ONLAY - PORCELAIN/CERAMIC 3/> SURFACES	$60
D6610	ONLAY - CAST HIGH NOBLE METAL 2 SURFACES*	$65
D6611	ONLAY-CAST HIGH NOBLE METAL 3/> SURFACES*	$70
D6612	ONLAY - CAST PREDOMINANTLY BASE METAL 2 SURFACES	$60
D6613	ONLAY - CAST PREDOMINANTLY BASE METAL 3/>SURFACES	$65
D6614	ONLAY - CAST NOBLE METAL 2 SURFACES*	$60
D6615	ONLAY - CAST NOBLE METAL 3/> SURFACES*	$60
D6624	INLAY TITANIUM *	$55
D6634	ONLAY TITANIUM*	$90
D6710	CROWN/INDIRECT RESIN BASED COMPOSITION	$25
D6720	CROWN - RESIN WITH HIGH NOBLE METAL*	$45
D6721	CROWN - RESIN PREDOMINANTLY BASE METAL	$35
D6722	CROWN - RESIN WITH NOBLE METAL*	$40
D6740	CROWN - PORCELAIN/CERAMIC	$120
D6750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL*	$120
D6751	CROWN - PORCELAIN FUSED PREDOMINANTLY BASE METAL	$110
D6752	CROWN - PORCELAIN FUSED NOBLE METAL*	$120
D6780	CROWN - 3/4 CAST HIGH NOBLE METAL*	$115
D6781	CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$110
D6782	CROWN - 3/4 CAST NOBLE METAL*	$115
D6783	CROWN - 3/4 PORCELAIN/CERAMIC	$115
D6790	CROWN - FULL CAST HIGH NOBLE METAL*	$120
D6791	CROWN - FULL CAST BASE METAL	$110
D6792	CROWN - FULL CAST NOBLE METAL*	$120
D6794	CROWN TITANIUM*	$120
D6920	CONNECTOR BAR	$85
D6930	RECEMENT FIXED PARTIAL DENTURE	$5
D6940	STRESS BREAKER	$5
D6980	FIXED PARTIAL DENTURE REPAIR	$25
IMPLANT SERVICES		
D6010	SURGICAL PLACEMENT OF IMPLANT BODY/ENDOSTEAL IMPLANT	$1,950
D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	$1,950
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	$368
D6053	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR COMPLETELY EDENTULOUS ARCH	$1,840
D6054	IMPLANT/ABUTMENT SUPPORTED BY REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH	$1,840
D6055	CONNECTING BAR-IMPLANT SUPPORTED/ABUTMENT SUPPORTED	$540
D6056	PREFABRICATED/ABUTMENT INCLUDING MODIFICATION/PLACEMENT	$368
D6057	CUSTOM FABRICATED ABUTMENT - INCLUDES IMPLANT	$610
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,050
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED METAL CROWN (HIGH NOBLE METAL)*	$915
D6060	ABUTMENT SUPPORTED PORCELAIN METAL CROWN (PREDOMINANTLY BASE METAL)	$1,050
D6061	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)*	$946
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)*	$981
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL)	$854
D6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)*	$1,168

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D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,144
D6066	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL) *	$1,083
D6067	IMPLANT SUPPORTED METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)*	$962
D6068	ABUTMENT SUPPORTED RETAINER PORCELAIN/CERAMIC FPD	$1,026
D6069	ABUTMENT SUPPORTED RETAINER PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL)	$1,050
D6070	ABUTMENT SUPPORTED RETAINER PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL)	$965
D6071	ABUTMENT SUPPORTED RETAINER PORCELAIN FUSED TO METAL FPD (NOBLE METAL)*	$984
D6072	ABUTMENT SUPPORTED RETAINER CAST METAL FPD (HIGH NOBLE METAL)*	$997
D6073	ABUTMENT SUPPORTED RETAINER CAST METAL FPD (PREDOMINANTLY BASE METAL)	$910
D6074	ABUTMENT SUPPORTED RETAINER CAST METAL FPD (NOBLE METAL)*	$967
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$1,018
D6076	IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL*	$992
D6077	IMPLANT SUPPORTED RETAINER CAST METAL FPD (TITANIUM, TITANIUM ALLOY OR HIGH NOBLE METAL)*	$962
D6080	IMPLANT MAINTENANCE PROCEDURE WHEN PROSTHESIS ARE REMOVED & INSERTED, INCLUD CLEANSING OF PROSTHESES AND ABUTMENTS	$55
D6090	REPAIR IMPLANT SUPPORTED BY PROSTHESIS, BY REPORT	$135
D6091	REPLACEMENT SEMI-PRECISION OR PRECISION ATTACHMENT IMPLANT/ABUTMENT PROSTHESIS BY REPORT	$410
D6092	RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN	$79
D6093	RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$124
D6094	ABUTMENT SUPPORTED CROWN (TITANIUM)*	$810
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$55
D6100	IMPLANT REMOVAL, BY REPORT	$600
D6101	DEBRIDEMENT OF A PERIIMPLANT DEFECT & SURFACE CLEAN EXPOSED IMPLANT SURFACE, INCLUD FLAP ENTRY & CLOSURE	$20
D6102	DEBRIDEMENT & OSSEOUS CONTOURING OF A PERIIMPLANT DEFECT; INCLDE SURFACE CLEAN OF EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE	$60
D6103	BONE GRAFT FOR REPAIR OF PERIIMPLANT DEFECT–NOT INCLUD FLAP ENTRY & CLOSURE OR, WHEN INDICATED, PLACEMENT OF BARRER MEMBRANE OR BIOLOG MATERIAL TO AID OSSEOUS REGENERATION	$350
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$265
D6194	ABUTMENT SUPPORTER RETAINER CAST METAL FPD (NOBLE METAL)*	$835

ORAL SURGERY SERVICES

D7111	EXTRACT CORONAL REMNANTS DECIDUOUS TOOTH	$5
D7140	EXTRACT ERUPTED TOOTH/EXPOSED ROOT	$10
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING BONE AND/OR SECTIONING TOOTH	$10
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	$30
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	$55
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	$40
D7241	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATION	$65
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$15
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	$10
D7261	PRIMARY CLOSURE OF SINUS PERFORATION	$30
D7270	TOOTH REIMPLANT AND/OR STABILIZATION ACCIDENT EVULSED OR DISPLACED TOOTH	$20
D7280	SURGICAL ACCESS OF UNERUPTED TOOTH	$25
D7282	MOBILIZATION OF ERUPTED/MALPOSITIONED TEETH	$15
D7285	BIOPSY OF ORAL TISUE - HARD (BONE, TOOTH)	$15
D7286	BIOPSY OF ORAL TISSUE - SOFT	$15
D7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$10
D7288	BRUSH BIOPSY, TRANSEPITHELIAL SAMPLE COLLECTION	$10
D7290	SURGICAL REPOSITIONING OF TEETH	$30
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$15
D7311	ALVEOLOPLASTY CONJNCT XTRCT 1-3 TEETH	$10
D7320	ALVEOLOPLASTY NOT IN CONJUNCT W/EXTRACTIONS - 4/> TEETH/SPACE, PER QUADRANT	$20
D7321	ALVEOLOPLASTY NOT IN CONJUNCT W/XTRCT 1-3 TEETH	$15
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$45
D7350	VESTIBULOPLASTY - RIDGE EXTENSION	$75
D7450	REMOVAL BENIGN ODONTOGENIC CYST/TUMOR UP TO 1.25 CM	$45
D7451	REMOVAL BENIGN ODONTOGENIC CYST/TUMOR >1.25 CM	$70
D7460	REMOVAL BENIGN NONODONTOGENIC CYST/TUMOR UP TO 1.25 CM	$50
D7461	REMOVAL BENIGN NONODONTOGENIC CYST/TUMOR >1.25 CM	$75
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	$45
D7472	REMOVAL OF TORUS PALATINUS	$70
D7473	REMOVAL OF TORUS MANDIBULARIS	$45
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY	$60
D7510	INCISION & DRAINAGE ABSCESS-INTRAORAL SOFT TISSUE	$15
D7511	INCISION & DRAINAGE ABSCESS INTRAORAL SOFT TISSUE COMPLICATED	$15
D7520	INCISION & DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE	$25
D7521	INCISION & DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE COMPLICATED	$25
D7530	REMOVAL FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE	$15
D7910	REMOVAL OF REACTION PRODUCING FOREIGN BODIES, MUSCULOSKELETAL SYSTEM	$5
D7960	FRENULECTOMY-ALSO KNOWN AS FRENECTOMY OR FRENOTOMY-SEPAR PROCED NOT INCIDENTAL TO ANOTHER	$15
D7963	FRENULOPLASTY	$15
D7970	EXCISION HYPERPLASTIC TISSUE - PER ARCH	$20
D7971	EXCISION OF PERICORONAL GINGIVA	$20
D7972	SURGICAL REDUCTION FIBROUS TUBEROSITY	$45

ADJUNCTIVE GENERAL SERVICES

D9110	PALLIATVE TREATMENT DENTAL PAIN - MINOR PROCEDURE	$5
D9120	FIXED PARTIAL DENTURE SECTIONING	$15
D9210	LOCAL ANESTHESIA NOT IN CONJUNCT W/OPERATIVE. SURGICAL PROCEDURE	$5
D9211	REGIONAL BLOCK ANESTHESIA	$5

ADA	DESCRIPTION	MEMBER'S COPAYMENT
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA	$5
D9215	LOCAL ANESTHESIA IN CONJUNCTION W TH OPERATIVE OR SURGICAL PROCEDURE	$0
D9220	DEEP SEDATION/GENERAL ANESTHESIA - 1ST 30 MIN	$25
D9221	DEEP SEDATION/GENERAL ANESTHESIA-EACH ADDL15 MIN	$15
D9230	INHALATION OF NITROUS OXIDE/ANALGESIA, ANXIOLYSIS	$5
D9241	IV CONSCIOUS SEDATION/ANALGESIA -1ST 30 MIN	$20
D9242	IV CONSCIOUS SEDATION/ANALGESIA EACH ADDL 15 MIN	$10
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	$15
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST/ PHYSICIAN OTHER THAN REQUST DENTIST/PHYSICIAN	$5
D9430	OFFICE VISIT - OBSERV - NO OTHER SERVICES PERFORMED	$5
D9440	OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS	$10
D9930	TREATMENT OF COMPLICATIONS - POST SURGICAL	$0
D9940	OCCLUSAL GUARD BY REPORT	$35
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$5
D9952	OCCLUSAL ADJUSMENT - COMPLETE	$20
D9971	ODONTOPLASTY - ONE TO THREE TEETH	$5
D9972	EXTERNAL BLEACHING - PER ARCH	$125
ORTHODONTIC SERVICES		
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION	$1,500
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$1,500
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$1,500
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLICANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S)	$150
D8999	START-UP FEE (INCLUDING EXAM, BEGINNING RECORDS, X-RAYS, TRACING, PHOTOS, AND MODELS	$350

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

Dental Exclusions and Limitations

Limitations of Benefits

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

1. DENTAL PROPHYLAXIS - limited to 1 time per 6 months.
2. INTRAORAL - Complete Series (including bitewings) - Limited to 1 time in any 2-year period.
3. INTRAORAL BITEWING RADIOGRAPHS - Limited to 1 series of 4 films in any 6 month period.
4. FLUORIDE TREATMENTS - Limited to 1 time per 6 months.
5. SCALING AND ROOT PLANING - Limited to 4 quadrants per calendar year.
6. PERIODONTAL MAINTENANCE PROCEDURES - Limited to once every 6 months, following active therapy, exclusive of gross debridement.
7. REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (Major Restorative Services) - Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 years from initial or supplemental placement.
8. REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (Major Restorative Services) - Replacement of complete dentures, and fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
9. CROWNS - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
10. CROWNS - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
11. TEMPORARY CROWNS - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
12. INLAYS/ONLAYS - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
13. INLAYS/ONLAYS - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14. STAINLESS STEEL CROWNS - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.
15. CROWNS, FIXED BRIDGES, AND IMPLANTS - The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12 month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Charges.
16. POST AND CORES - Covered only for teeth that have had root canal therapy.
17. ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS - Limited to repairs or adjustments performed more than 6 months after the initial insertion.
18. INTRAVENOUS SEDATION OR GENERAL ANESTHESIA - Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).
19. ADJUNCTIVE - Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesion, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS, ONLAYS, AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROSTHESIS - Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implant crowns, implant prostheses previously submitted for payment under the plan is limited to 1 time per tooth per 5 years from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable orthodontic appliances.
21. All Specialty Referral Services Must Be: (A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's Participating Dentist. Any Covered Person who elects specialist care without prior referral by his or her Participating Dentist and approval by us is responsible for all charges incurred.
    • In order for specialty services to be Covered by this plan, the following referral process must be followed:
    • A Covered Person's Participating Dentist must coordinate all Dental Services.
    • When the care of a Network Specialist Dentist is required, the Covered Person's Participating Dentist must contact us and request authorization.
    • If the Participating Dentist request for specialist referral is denied, the Participating Dentist and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the Participating Dentist may be asked to perform the service.
    • Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
    • Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

Exclusion of Benefits

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

1. Dental Services that are not Necessary.
2. Any Dental Services or Procedures not listed in the Schedule of CoveredDental Services.
3. Any Dental Procedure not performed in a dental setting. This will not apply to Covered Emergency Dental Services.
4. Any Dental Procedure not directly associated with dental disease.
5. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
6. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
7. Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Primary Care Dentist, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
10. Removable Prosthetics/Fixed Prosthetics/Crowns, Inlays and Onlays (Major Restorative Services) - The plan provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, the Covered Person must pay: (a) the Copayment for the inlay, onlay, crown or fixed bridge; and (b) an added charge equal to the actual laboratory cost of the high noble metal.
11. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
12. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
13. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
14. Dental Services otherwise Covered under the Contract, but rendered after the date individual Coverage under the Contract terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Contract terminates.
15. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by a Participating Dentist; or (b) treatment by a specialist without referral from a Participating Dentist and our approval.
17. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
18. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
19. Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
20. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
21. Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.

Orthodontic Exclusions & Limitations

If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the Covered Person will be responsible for all costs associated with any orthodontic treatment. Orthodontic services Copayments are valid for authorized services rendered.

If you terminate Coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. The following are not covered orthodontic benefits:
    - Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
    - Treatment in progress prior to the effective date of this coverage
    - Extractions required for orthodontic purposes
    - Surgical orthodontics or jaw repositioning
    - Myofunctional therapy
    - Cleft palate
    - Micrognathia
    - Macroglossia
    - Hormonal imbalances
    - Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of treatment of accident
    - Palatal expansion appliances
    - Services performed by outside laboratories

2. If a treatment plan is for less than 24 months, then a prorated portion of the full copayment shall apply.

3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.

4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist.

5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this Comprehensive Orthodontic Treatment. If comprehensive treatment is necessary, and is completed within a 24 month period, the Copayments listed will apply. If necessary and active treatment extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.

