UNITEDHEALTHCARE / NEVADA PACIFIC DENTAL
SELECT MANAGED CARE - DIRECT COMPENSATION PLANS
QUICK REFERENCE GUIDE (QRG)

Web Site Offers many time-saving features including eligibility verification, claims status and network specialist locations.	**www.uhcdental.com**
Using our website to locate Dentists including Specialists: After Login, Select "Dentist Referral" on the left side bar. Select the applicable Plan Name listed on the right.	**NV SELECT MANAGED CARE / NV PACIFIC DENTAL**
Specialty Referral Process: **Pre-Authorization:** General Dentist must obtain preauthorization for all specialty services. Services without prior authorization will not be covered.	**PRE-AUTHORIZATION**
Member ID Cards The following brand names are found on the member id cards for your reference.	UnitedHealthcare
Integrated Voice Response (IVR) System **>** Enables you to access information 24 hours a day by responding to the system's voice prompts. > Obtain immediate eligibility information > Assign a member to your office (Voluntary basis) > Obtain claims status and copies of EOB's > Fax eligibility confirmation directly to the caller	**1-866-345-1090**
Dedicated Toll Free Customer Service: Knowledgeable trained specialists who can handle specific dentist issues such as eligibility, claims and dental plan information.	**1-800-926-0925**
Provider Relations Questions regarding fee schedules, monthly rosters and contracts	**1-800-926-0925**
Emergency Specialty Referral Phone Number	**1-800-926-0925**
Address: Claims	**P.O. Box 30567 Salt Lake City, UT 84130**
Specialty Referral and Pre-Treatment Estimates	**P.O. Box 30552 Salt Lake City, UT 84130**
Written Inquiries and Appeals	**P.O. Box 30569 Salt Lake City, UT 84130**
Electronic Claims Submission - Payor ID #	**52133**
Request for Specialty Referral Form and Provider Manual	**1-800-926-0925**

PRODUCT ID:	PLAN NAME:	EXCLUSION / LIMITATIONS VERSION & PLAN BENEFITS:
D0012099	NV Individual 1000 (D001I)	IND Plan E&L
D0012751	Aon Exchange Platinum NV DHMO 500 Plan DD026	Gen E&L
D0012850	NV 10I Plan (D501N)	Gen E&L
D0012851	NV 10-I-5C Plan (D502C)	Gen E&L
D0012852	NV 10-I-5C Plan (D503C)	Gen E&L
D0012853	NV 10-I-10C Plan (D504C)	Gen E&L
D0012854	NV 10-I-10C Plan (D505C)	Gen E&L
D0012855	NV 20I Plan (D506N)	Gen E&L
D0012856	NV 20I Plan (D507N)	Gen E&L
D0012857	NV 20-I-5C Plan (D508C)	Gen E&L
D0012859	NV 20-I-10C Plan (D510C)	Gen E&L
D0012860	NV 20-I-10C Plan (D511C)	Gen E&L
D0012861	NV 30I Plan (D512N)	Gen E&L
D0012862	NV 30I Plan (D513N)	Gen E&L
D0012864	NV 30-I-5C Plan (D515C)	Gen E&L
D0012865	NV 30-I-10C Plan (D516C)	Gen E&L
D0012866	NV 30-I-10C Plan (D517C)	Gen E&L
D0012872	NV 40-I-10C Plan (D523C)	Gen E&L
D0012877	NV 50-I-10C Plan (D528C)	Gen E&L
D0012879	NV 10I Plan (D500N)	Gen E&L
D0014305	NV 20-I-5C Plan (D509C)	Gen E&L
D0018633	Aon Exchange Platinum NV DHMO 500 Plan D1088	Gen E&L
D0021628	D1093 Southwest Carpenters Health (NV)	Carpenter's Health E&L
D1000189	NV DC - AFFINITY 110 50/150 $1000 - Sequoia-Child (D0225)	Gen E&L
D1000367	NV DC - MAXIMA 110 50/150 $1000 - Sequoia-Child (D0230)	Gen E&L
D1000417	NV DC - VENTURA 125 50/150 $1000 - Sequoia-Child (D0235)	Gen E&L

UNITEDHEALTHCARE / NEVADA PACIFIC DENTAL
SELECT MANAGED CARE - DIRECT COMPENSATION PLANS
PRINCIPAL BENEFITS AND COVERAGES - MEMBER COPAYMENT SCHEDULE
EXHIBIT 2B

CDT CODE	CDT DESCRIPTION / PLAN NAME	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500	D1093 Southwest Carpenters Health
[1] Please collect applicable copay for this procedure as listed on the copay schedule. The member's copayment is the total compensation for this procedure. If the procedure is not covered under the plan, the member is responsible for the provider's UCR fee										
I. DIAGNOSTIC										
D0120	periodic oral evaluation – established patient	25	0	0	0	0	0	0	0	0
D0140	limited oral evaluation – problem focused	30	0	0	0	0	0	0	0	0
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	30	0	0	0	0	0	0	NTCV	0
D0150	comprehensive oral evaluation – new or established patient	30	0	0	0	0	0	0	0	0
D0160	detailed and extensive oral evaluation – problem focused, by report	45	0	0	0	0	0	NTCV	0	0
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)	25	0	0	0	0	0	0	0	0
D0171	re-evaluation – post-operative office visit	19	5	5	5	5	NTCV	10	NTCV	0
D0180	comprehensive periodontal evaluation – new or established patient	30	0	0	0	0	0	NTCV	0	0
D0190	screening of a patient	19	5	5	5	5	5	70	NTCV	5
D0191	assessment of a patient	19	5	5	5	5	5	70	NTCV	5
D0210	intraoral – complete series of radiographic images	60	0	0	0	0	0	0	0	0
D0220	intraoral – periapical first radiographic image	10	0	0	0	0	0	0	0	0
D0230	intraoral – periapical each additional radiographic image	5	0	0	0	0	0	0	0	0
D0240	intraoral – occlusal radiographic image	12	0	0	0	0	0	0	0	0
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	20	0	0	0	0	0	0	0	0
D0251	extra-oral posterior dental radiographic image	20	0	0	0	0	0	0	0	0
D0270	bitewing – single radiographic image	8	0	0	0	0	0	0	0	0
D0272	bitewings – two radiographic images	10	0	0	0	0	0	0	0	0
D0273	bitewings – three radiographic images	14	0	0	0	0	0	0	0	0
D0274	bitewings – four radiographic images	18	0	0	0	0	0	0	0	0
D0277	vertical bitewings – 7 to 8 radiographic images	18	0	0	0	0	0	0	0	0
D0330	panoramic radiographic image	25	5	0	0	0	0	0	0	0
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	40	0	0	0	0	0	NTCV	NTCV	10
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	48	25	0	0	0	0	10	NTCV	5
D0414	laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	24	0	0	0	0	0	NTCV	0	0
D0415	collection of microorganisms for culture and sensitivity	24	0	0	0	0	0	NTCV	0	0
D0416	viral culture	24	0	0	0	0	0	NTCV	NTCV	0
D0422	collection and preparation of genetic sample material for laboratory analysis and report	24	0	0	0	0	0	NTCV	0	NTCV
D0423	genetic test for susceptibility to diseases – specimen analysis	24	0	0	0	0	0	NTCV	0	NTCV
D0425	caries susceptibility tests	24	0	0	0	0	0	0	0	0
D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	45	20	20	20	20	20	NTCV	20	0
D0460	pulp vitality tests	24	0	0	0	0	0	NTCV	0	0
D0470	diagnostic casts	25	12	0	0	0	0	0	0	0
D0472	accession of tissue, gross examination, preparation and transmission of written report	25	0	0	0	0	0	0	0	0

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D0473	accession of tissue, gross and microscopic examination, preparation and transmission of written report	65	0	0	0	0	0	NTCV	0	0
D0474	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	65	0	0	0	0	0	NTCV	0	0
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	24	0	0	0	0	0	NTCV	0	NTCV
D0601	caries risk assessment and documentation, with a finding of low risk	30	0	0	0	0	NTCV	0	0	0
D0602	caries risk assessment and documentation, with a finding of moderate risk	30	0	0	0	0	NTCV	0	0	0
D0603	caries risk assessment and documentation, with a finding of high risk	30	0	0	0	0	NTCV	0	0	0
D0999	Office visit Fee- Per visit	0 [1]	$0/ $5/ $10	$0/ $5/ $10	$0/ $5/ $10	$0/ $5/ $10	$0/ $5/ $10	0	0	0
II. PREVENTIVE										
[2] Additional Prophy within 6 months will be based upon the necessity recommended by the provider										
D1110	prophylaxis – adult	45	5	0	0	0	0	0	0	0
--------	Prophylaxis - Adult [2] **Additional Prophy within 6 months**	0 [1]	25	25	25	25	25	NTCV	25	0
D1120	prophylaxis – child	28	5	0	0	0	0	0	0	0
--------	Prophylaxis -Child [2] **Additional Prophy within 6 months**	0 [1]	25	25	25	25	25	NTCV	25	0
D1206	topical application of fluoride varnish	13	0	0	0	0	0	0	0	0
D1208	topical application of fluoride – excluding varnish	13	0	0	0	0	0	0	0	0
D1310	nutritional counseling for control of dental disease	0 [1]	0	0	0	0	0	0	0	0
D1320	tobacco counseling for the control and prevention of oral disease	0 [1]	0	0	0	0	0	0	0	0
D1330	oral hygiene instructions	0 [1]	0	0	0	0	0	0	0	0
D1351	sealant – per tooth	16	10	8	8	5	5	18	12	0
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth	16	12	10	10	8	8	NTCV	NTCV	0
D1353	sealant repair – per tooth	16	10	8	8	5	NTCV	18	12	0
D1510	space maintainer – fixed, unilateral	80	35	25	25	25	15	85	80	0
D1516	space maintainer – fixed – bilateral, maxillary	160	35	25	25	25	15	135	117	0
D1517	space maintainer – fixed – bilateral, mandibular	160	35	25	25	25	15	135	117	0
D1520	space maintainer – removable – unilateral	100	45	40	40	35	20	100	80	0
D1526	space maintainer – removable – bilateral, maxillary	140	45	40	40	35	20	140	117	0
D1527	space maintainer – removable – bilateral, mandibular	140	45	40	40	35	20	140	117	0
D1550	re-cement or re-bond space maintainer	12	15	15	15	5	0	15	26	0
D1555	removal of fixed space maintainer	10	15	15	15	10	10	12	18	0
D1575	distal shoe space maintainer – fixed – unilateral	80	35	25	25	25	15	85	80	0
III. RESTORATIVE										
D2140	amalgam – one surface, primary or permanent	40	15	8	0	0	0	35	8	5
D2150	amalgam – two surfaces, primary or permanent	60	20	15	0	0	0	40	15	5
D2160	amalgam – three surfaces, primary or permanent	75	25	22	0	0	0	50	22	10
D2161	amalgam – four or more surfaces, primary or permanent	90	30	28	0	0	0	55	28	10
D2330	resin-based composite – one surface, anterior	40	20	10	0	0	0	40	20	5
D2331	resin-based composite – two surfaces, anterior	60	25	20	0	0	0	60	28	5
D2332	resin-based composite – three surfaces, anterior	70	30	30	0	0	0	75	30	10

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D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)	80	40	38	0	0	0	90	38	10
D2390	resin-based composite crown, anterior	85	70	45	40	25	20	NTCV	104	20
D2391	resin-based composite – one surface, posterior	40	65	50	40	30	25	70	50	5
D2392	resin-based composite – two surfaces, posterior	60	85	55	45	40	35	80	55	10
D2393	resin-based composite – three surfaces, posterior	75	105	85	75	55	45	105	85	10
D2394	resin-based composite – four or more surfaces, posterior	90	120	95	75	55	45	120	95	10
D2510	inlay – metallic – one surface	125	200	185	175	150	115	325	276	95
D2520	inlay – metallic – two surfaces	150	200	185	175	150	115	335	276	95
D2530	inlay – metallic – three or more surfaces	175	200	185	175	150	115	345	283	95
D2542	onlay – metallic – two surfaces	205	250	225	225	150	115	NTCV	270	95
D2543	onlay – metallic – three surfaces	205	250	225	225	150	115	NTCV	361	95
D2544	onlay – metallic – four or more surfaces	205	250	225	225	150	115	NTCV	361	95
D2610	inlay – porcelain/ceramic – one surface	125	305	250	250	175	125	350	212	35
D2620	inlay – porcelain/ceramic – two surfaces	150	305	250	250	175	125	360	229	40
D2630	inlay – porcelain/ceramic – three or more surfaces	175	305	250	250	175	125	375	244	45
D2642	onlay – porcelain/ceramic – two surfaces	205	305	250	250	175	125	NTCV	254	95
D2643	onlay – porcelain/ceramic – three surfaces	205	305	250	250	175	125	NTCV	264	95
D2644	onlay – porcelain/ceramic – four or more surfaces	205	305	250	250	175	125	NTCV	264	95
D2650	inlay – resin-based composite – one surface	110	305	250	250	175	125	NTCV	283	30
D2651	inlay – resin-based composite – two surfaces	125	305	250	250	175	125	NTCV	283	35
D2652	inlay – resin-based composite – three or more surfaces	145	305	250	250	175	125	NTCV	283	40
D2662	onlay – resin-based composite – two surfaces	115	305	250	250	175	125	NTCV	303	30
D2663	onlay – resin-based composite – three surfaces	150	305	250	250	175	125	NTCV	303	40
D2664	onlay – resin-based composite – four or more surfaces	175	305	250	250	175	125	NTCV	308	45
D2710	crown – resin-based composite (indirect)	160	180	150	150	125	90	175	157	20
D2712	crown – ¾ resin-based composite (indirect)	160	180	150	150	125	90	175	312	20
D2720	crown – resin with high noble metal*	320	250	250	250	175	125	390	283	40
D2721	crown – resin with predominantly base metal	240	250	250	250	175	125	375	246	30
D2722	crown – resin with noble metal*	272	250	250	250	175	125	405	246	30
D2740	crown – porcelain/ceramic	320	350	300	300	225	215	475	360	100
D2750	crown – porcelain fused to high noble metal*	352	305	250	250	175	125	405	322	100
D2751	crown – porcelain fused to predominantly base metal	256	305	250	250	175	125	375	322	90
D2752	crown – porcelain fused to noble metal*	288	305	250	250	175	125	405	322	100
D2780	crown – ¾ cast high noble metal*	304	305	250	250	175	125	NTCV	250	95
D2781	crown – ¾ cast predominantly base metal	288	305	250	250	175	125	NTCV	250	90
D2782	crown – ¾ cast noble metal*	290	305	250	250	175	125	NTCV	250	95
D2783	crown – ¾ porcelain/ceramic	352	305	250	250	175	125	NTCV	272	95
D2790	crown – full cast high noble metal*	304	305	250	250	175	125	405	309	100
D2791	crown – full cast predominantly base metal	240	305	250	250	175	125	375	309	90
D2792	crown – full cast noble metal*	256	305	250	250	175	125	405	309	100
D2794	crown – titanium*	304	305	250	250	175	125	475	309	100

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D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	24	10	0	0	0	0	24	26	5
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	24	10	0	0	0	0	24	26	5
D2920	re-cement or re-bond crown	24	10	0	0	0	0	24	26	5
D2921	reattachment of tooth fragment, incisal edge or cusp	20	5	55	55	55	NTCV	NTCV	NTCV	5
D2930	prefabricated stainless steel crown – primary tooth	64	60	25	25	25	10	65	71	10
D2931	prefabricated stainless steel crown – permanent tooth	96	60	25	25	25	10	65	77	10
D2932	prefabricated resin crown	48	45	40	40	35	10	95	86	10
D2933	prefabricated stainless steel crown with resin window	75	60	40	40	35	20	NTCV	76	10
D2934	prefabricated esthetic coated stainless steel crown – primary tooth	64	65	45	45	40	25	NTCV	NTCV	10
D2940	protective restoration	24	10	0	0	0	0	24	26	5
D2941	interim therapeutic restoration – primary dentition	192	10	0	0	0	NTCV	NTCV	26	5
D2950	core buildup, including any pins when required	96	70	50	50	25	10	85	75	5
D2951	pin retention – per tooth, in addition to restoration	16	15	10	10	10	8	25	15	5
D2952	post and core in addition to crown, indirectly fabricated	128	50	50	40	35	20	125	103	25
D2953	each additional indirectly fabricated post – same tooth	40	50	50	40	25	10	NTCV	102	5
D2954	prefabricated post and core in addition to crown	80	30	30	25	20	10	75	82	10
D2955	post removal	86	10	10	10	10	10	40	64	20
D2957	each additional prefabricated post – same tooth	40	30	30	30	30	15	NTCV	62	5
D2960	labial veneer (resin laminate) – chairside	150	300	300	300	300	300	NTCV	NTCV	20
D2961	labial veneer (resin laminate) – laboratory	200	450	450	450	450	450	NTCV	NTCV	40
D2962	labial veneer (porcelain laminate) – laboratory	194	550	550	550	550	550	NTCV	NTCV	40
D2971	additional procedures to construct new crown under existing partial denture framework	45	50	50	50	35	25	NTCV	50	10
D2980	crown repair necessitated by restorative material failure	62	55	55	55	40	30	NTCV	NTCV	15
D2981	inlay repair necessitated by restorative material failure	62	5	5	NTCV	NTCV	NTCV	NTCV	NTCV	NTCV
D2982	onlay repair necessitated by restorative material failure	62	5	5	NTCV	NTCV	NTCV	NTCV	NTCV	NTCV
D2983	veneer repair necessitated by restorative material failure	62	550	550	NTCV	NTCV	NTCV	NTCV	NTCV	NTCV
D2990	resin infiltration of incipient smooth surface lesions	16	0	0	NTCV	NTCV	NTCV	0	0	10
IV. ENDODONTICS										
D3110	pulp cap – direct (excluding final restoration)	20	5	5	0	0	0	22	17	0
D3120	pulp cap – indirect (excluding final restoration)	16	5	5	0	0	0	18	17	0
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	48	25	5	0	0	0	52	43	0
D3221	pulpal debridement, primary and permanent teeth	48	55	30	30	15	5	NTCV	45	5
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	48	55	30	30	15	5	75	NTCV	0
D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	66	40	40	40	25	5	65	53	0
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	55	40	40	40	25	5	85	60	0
D3310	endodontic therapy, anterior tooth (excluding final restoration)	170	125	125	95	75	45	240	206	15
D3320	endodontic therapy, premolar tooth (excluding final restoration)	240	215	175	175	150	75	350	277	20
D3330	endodontic therapy, molar tooth (excluding final restoration)	400	365	325	305	275	115	400	335	60
D3331	treatment of root canal obstruction; non-surgical access	52	115	85	85	85	65	NTCV	147	5
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	48	115	85	85	65	45	110	146	0

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D3333	internal root repair of perforation defects	55	115	85	85	65	45	NTCV	51	5
D3346	retreatment of previous root canal therapy – anterior	220	155	145	115	100	70	500	232	15
D3347	retreatment of previous root canal therapy – premolar	290	245	195	175	170	100	600	296	20
D3348	retreatment of previous root canal therapy – molar	450	415	345	300	295	140	725	354	35
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	42	70	70	70	65	50	NTCV	125	5
D3352	apexification/recalcification – interim medication replacement	40	70	70	70	65	45	NTCV	125	5
D3353	apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	75	70	70	70	65	45	NTCV	125	10
D3355	Pulpal regeneration - initial visit	42	70	70	70	70	NTCV	NTCV	125	5
D3356	Pulpal regeneration -interim medicament replacement	40	70	70	70	70	NTCV	NTCV	125	5
D3357	Pulpal regeneration - completion of treatment	75	70	70	70	65	NTCV	NTCV	125	10
D3410	apicoectomy – anterior	112	115	95	95	95	75	470	167	15
D3421	apicoectomy – premolar (first root)	224	125	95	95	95	75	535	193	20
D3425	apicoectomy – molar (first root)	336	140	95	95	95	75	575	206	30
D3426	apicoectomy (each additional root)	144	95	55	55	55	35	145	90	10
D3427	periradicular surgery without apicoectomy	144	95	55	55	55	NTCV	145	90	13
D3430	retrograde filling – per root	134	60	55	55	55	35	135	64	10
D3450	root amputation – per root	96	110	95	95	95	75	315	122	12
D3910	surgical procedure for isolation of tooth with rubber dam	40	25	15	15	15	15	NTCV	20	5
D3920	hemisection (including any root removal), not including root canal therapy	96	90	90	90	90	75	95	122	5
D3950	canal preparation and fitting of preformed dowel or post	50	15	15	15	15	15	NTCV	90	5
V. PERIODONTICS: Includes pre-op and post-op evaluations and local anesthetic; charting must be performed in conjunction with these procedures										
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	96	150	130	115	115	50	265	174	10
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	48	95	85	80	75	35	150	52	5
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	16	31	28	26	25	12	NTCV	17	0
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	96	160	150	150	140	115	350	225	10
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	64	115	110	95	85	85	280	52	5
D4245	apically positioned flap	100	175	165	165	165	155	NTCV	348	10
D4249	clinical crown lengthening – hard tissue	95	175	150	145	115	115	275	309	10
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	320	385	355	325	325	225	650	201	30
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	211	300	275	225	215	155	525	299	20
D4263	bone replacement graft – retained natural tooth – first site in quadrant	175	235	205	175	175	175	NTCV	299	15
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant	175	90	90	90	75	75	NTCV	234	NTCV
D4270	pedicle soft tissue graft procedure	192	255	235	225	215	195	295	328	10

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CDT CODE	CDT DESCRIPTION / PLAN NAME	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500	D1093 Southwest Carpenters Health
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	100	100	90	85	65	50	NTCV	161	10
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	192	255	235	225	215	195	315	307	15
D4320	provisional splinting – intracoronal	95	95	95	95	95	95	NTCV	NTCV	10
D4321	provisional splinting – extracoronal	75	75	75	75	75	75	NTCV	NTCV	5
D4341	periodontal scaling and root planing – four or more teeth per quadrant	70	55	55	45	40	25	80	71	5
D4342	periodontal scaling and root planing – one to three teeth per quadrant	50	55	50	45	28	15	65	32	5
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	55	40	40	30	30	15	65	53	0
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	60	55	55	50	40	25	80	55	5
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	25	65	65	55	35	55	NTCV	50	5
D4910	periodontal maintenance	55	40	40	30	30	15	65	53	0
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	18	0	0	0	0	0	NTCV	25	0
D4921	gingival irrigation - per quadrant	13	0	0	0	NTCV	0	0	0	0
VI. PROSTHODONTICS (REMOVABLE): Full and partial dentures; includes fabrication and/or repair of prosthesis and routine post-delivery care										
D5110	complete denture – maxillary	500	425	350	275	225	150	450	452	140
D5120	complete denture – mandibular	500	425	350	275	225	150	450	452	140
D5130	immediate denture – maxillary	540	440	400	315	250	150	495	464	140
D5140	immediate denture – mandibular	540	440	400	315	250	150	495	464	140
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	350	400	325	250	275	115	425	452	40
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	350	400	325	250	275	115	425	452	40
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	400	450	425	325	275	165	475	464	140
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	400	450	425	325	275	165	475	464	140
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	160	160	145	115	115	45	195	276	30
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	160	170	145	115	115	45	195	276	30
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	160	160	145	115	115	45	195	276	30
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	160	170	145	115	115	45	195	276	30
D5225	maxillary partial denture – flexible base (including any clasps, rests and teeth)	350	450	425	325	350	325	475	650	40
D5226	mandibular partial denture – flexible base (including any clasps, rests and teeth)	350	450	425	325	350	325	475	650	40
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	125	330	300	275	260	150	415	257	20

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D5283	removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	125	330	300	275	260	150	415	257	20
D5410	adjust complete denture – maxillary	16	15	10	10	0	0	22	20	5
D5411	adjust complete denture – mandibular	16	15	10	10	0	0	22	20	5
D5421	adjust partial denture – maxillary	27	15	10	10	0	0	22	20	5
D5422	adjust partial denture – mandibular	27	15	10	10	0	0	22	20	5
D5511	repair broken complete denture base, mandibular	48	15	10	10	10	0	22	20	10
D5512	repair broken complete denture base, maxillary	48	15	10	10	10	0	22	20	10
D5611	repair resin partial denture base, mandibular	48	15	10	10	10	0	22	20	10
D5612	repair resin partial denture base, maxillary	48	15	10	10	10	0	22	20	10
D5621	repair cast partial framework, mandibular	96	15	10	10	10	0	22	20	25
D5622	repair cast partial framework, maxillary	96	15	10	10	10	0	22	20	25
D5630	repair or replace broken clasp – per tooth	96	40	35	30	25	15	65	69	25
D5640	replace broken teeth – per tooth	48	40	35	30	25	15	65	56	10
D5650	add tooth to existing partial denture	48	40	40	30	25	15	55	56	10
D5660	add clasp to existing partial denture – per tooth	80	50	40	30	25	15	90	59	20
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	315	165	150	150	150	125	350	145	45
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	315	165	150	150	150	125	350	145	45
D5710	rebase complete maxillary denture	160	105	75	65	55	45	185	188	40
D5711	rebase complete mandibular denture	160	105	75	65	55	45	185	188	40
D5720	rebase maxillary partial denture	128	105	75	65	55	45	185	188	30
D5721	rebase mandibular partial denture	128	105	75	65	55	45	185	188	30
D5730	reline complete maxillary denture (chairside)	96	90	55	55	35	0	100	94	25
D5731	reline complete mandibular denture (chairside)	96	90	55	55	35	0	100	94	25
D5740	reline maxillary partial denture (chairside)	80	90	55	55	35	0	100	151	20
D5741	reline mandibular partial denture (chairside)	80	90	55	55	35	0	100	151	20
D5750	reline complete maxillary denture (laboratory)	128	115	75	75	55	40	175	151	30
D5751	reline complete mandibular denture (laboratory)	128	115	75	75	55	40	175	151	30
D5760	reline maxillary partial denture (laboratory)	128	115	75	75	55	40	175	151	30
D5761	reline mandibular partial denture (laboratory)	128	115	75	75	55	40	175	151	30
D5810	interim complete denture (maxillary)	192	160	145	115	55	45	300	NTCV	40
D5811	interim complete denture (mandibular)	192	170	155	115	55	45	300	NTCV	40
D5820	interim partial denture (maxillary)	160	160	145	115	55	45	195	276	30
D5821	interim partial denture (mandibular)	160	170	155	115	55	45	195	276	30
D5850	tissue conditioning, maxillary	24	35	20	20	10	10	40	40	5
D5851	tissue conditioning, mandibular	24	35	20	20	10	10	40	40	5
D5863	overdenture - complete maxillary	500	425	350	275	225	NOR	450	452	140
D5864	overdenture - complete mandibular	500	450	425	325	275	NOR	475	464	140
D5865	overdenture - partial maxillary	400	425	350	275	225	NOR	450	452	140
D5866	overdenture - partial mandibular	400	450	425	325	275	NOR	475	464	140
D5876	add metal substructure to acrylic full denture (per arch)	160	105	75	65	55	45	185	188	40

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VIII. IMPLANT SERVICES										
D6010	surgical placement of implant body: endosteal implant	0 [1]	1,950	1,950	1,950	1,950	1,950	NTCV	NTCV	1,950
D6013	surgical placement of a mini-implant	0 [1]	1,950	1,950	150	195	NTCV	NTCV	NTCV	1,950
D6051	connecting bar – implant supported or abutment supported	0 [1]	368	368	368	368	368	NTCV	NTCV	NTCV
D6052	semi-precision attachment abutment	0 [1]	368	368	368	275	NTCV	NTCV	NTCV	368
D6055	prefabricated abutment – includes modification and placement	0 [1]	540	540	540	540	540	NTCV	NTCV	540
D6056	custom fabricated abutment – includes placement	0 [1]	368	368	368	368	368	NTCV	NTCV	368
D6057	abutment supported porcelain/ceramic crown	0 [1]	610	610	610	610	610	NTCV	NTCV	610
D6058	abutment supported porcelain fused to metal crown (high noble metal)*	0 [1]	1,050	1,050	1,050	1,050	1,050	NTCV	NTCV	1,050
D6059	abutment supported porcelain fused to metal crown (predominantly base metal)	0 [1]	915	915	915	915	915	NTCV	NTCV	915
D6060	abutment supported porcelain fused to metal crown (noble metal)*	0 [1]	1,050	1,050	1,050	1,050	1,050	NTCV	NTCV	1,050
D6061	abutment supported cast metal crown (high noble metal)*	0 [1]	946	946	946	946	946	NTCV	NTCV	946
D6062	abutment supported cast metal crown (predominantly base metal)	0 [1]	981	981	981	981	981	NTCV	NTCV	981
D6063	abutment supported cast metal crown (noble metal)*	0 [1]	854	854	854	854	854	NTCV	NTCV	854
D6064	implant supported porcelain/ceramic crown	0 [1]	1,168	1,168	1,168	1,168	1,168	NTCV	NTCV	1,168
D6065	implant supported metal crown (titanium, titanium alloy, high noble metal)*	0 [1]	1,144	1,144	1,144	1,144	1,144	NTCV	NTCV	1,144
D6066	abutment supported retainer for porcelain/ceramic FPD	0 [1]	1,083	1,083	1,083	1,083	1,083	NTCV	NTCV	1,083
D6067	abutment supported retainer for porcelain fused to metal FPD (high noble metal)*	0 [1]	962	962	962	962	962	NTCV	NTCV	962
D6068	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	0 [1]	1,026	1,026	1,026	1,026	1,026	NTCV	NTCV	1,026
D6069	abutment supported retainer for porcelain fused to metal FPD (noble metal)*	0 [1]	1,050	1,050	1,050	1,050	1,050	NTCV	NTCV	1,050
D6070	abutment supported retainer for cast metal FPD (high noble metal)*	0 [1]	965	965	965	965	965	NTCV	NTCV	965
D6071	abutment supported retainer for cast metal FPD (predominantly base metal)	0 [1]	984	984	984	984	984	NTCV	NTCV	984
D6072	abutment supported retainer for cast metal FPD (noble metal)*	0 [1]	997	997	997	997	997	NTCV	NTCV	997
D6073	implant supported retainer for ceramic FPD	0 [1]	910	910	910	910	910	NTCV	NTCV	910
D6074	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)*	0 [1]	967	967	967	967	967	NTCV	NTCV	967
D6075	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)*	0 [1]	1,018	1,018	1,018	1,018	1,018	NTCV	NTCV	1,018
D6076	implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	0 [1]	992	992	992	992	992	NTCV	NTCV	992
D6077	repair implant supported prosthesis, by report*	0 [1]	962	962	962	962	962	NTCV	NTCV	962
D6080	replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	0 [1]	55	55	55	55	55	NTCV	NTCV	55
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	64	1,950	1,950	NTCV	NTCV	NOR	NTCV	NTCV	15
D6090	re-cement or re-bond implant/abutment supported crown	0 [1]	135	135	135	135	135	NTCV	NTCV	135
D6091	re-cement or re-bond implant/abutment supported fixed partial denture	0 [1]	410	410	410	410	410	NTCV	NTCV	410
D6092	abutment supported crown (titanium)	0 [1]	79	79	79	79	79	NTCV	NTCV	79
D6093	repair implant abutment, by report*	0 [1]	124	124	124	124	124	NTCV	NTCV	124
D6094	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)*	0 [1]	810	810	810	810	810	NTCV	NTCV	810

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D6095	implant removal, by report	0 [1]	55	55	55	55	55	NTCV	NTCV	55
D6096	remove broken implant retaining screw	86	55	55	55	55	55	NTCV	NTCV	20
D6100	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	0 [1]	600	600	600	600	600	NTCV	NTCV	600
D6101	interim abutment	64	115	110	95	85	85	NTCV	NTCV	15
D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	211	1,950	1,950	NTCV	NTCV	NOR	NTCV	NTCV	50
D6103	bone graft for repair of peri-implant defect – does not include flap entry and closure	175	1,950	1,950	NTCV	NTCV	NOR	NTCV	NTCV	350
D6110	implant /abutment supported removable denture for edentulous arch – maxillary	0	1,840	1,840	1,840	1,840	NOR	NTCV	NTCV	1,840
D6111	implant /abutment supported removable denture for edentulous arch – maxillary	0	1,840	1,840	1,840	1,840	NOR	NTCV	NTCV	1,840
D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary	0	1,840	1,840	1,840	1,840	NOR	NTCV	NTCV	1,840
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular	0	1,840	1,840	1,840	1,840	NOR	NTCV	NTCV	1,840
D6190	radiographic/surgical implant index, by report	0 [1]	265	265	265	265	265	NTCV	NTCV	265
D6194	abutment supported retainer crown for FPD – (titanium)*	0 [1]	835	835	835	835	835	NTCV	NTCV	835
IX. PROSTHODONTICS, FIXED: Includes diagnosis/models; preparation, temporization, fabrication and cementation of final restoration										
D6205	pontic – indirect resin based composite	200	180	150	150	125	90	NTCV	NTCV	20
D6210	pontic – cast high noble metal*	304	305	250	250	175	125	405	309	80
D6211	pontic – cast predominantly base metal	240	305	250	250	175	125	375	309	75
D6212	pontic – cast noble metal*	256	305	250	250	175	125	405	309	80
D6214	pontic – titanium*	304	305	250	250	175	125	NTCV	309	80
D6240	pontic – porcelain fused to high noble metal*	352	305	250	250	175	125	405	322	80
D6241	pontic – porcelain fused to predominantly base metal	256	305	250	250	175	125	375	322	75
D6242	pontic – porcelain fused to noble metal*	288	305	250	250	175	125	405	322	80
D6245	pontic – porcelain/ceramic	320	350	300	300	225	215	NTCV	357	95
D6250	pontic – resin with high noble metal*	320	250	250	250	175	125	405	283	25
D6251	pontic – resin with predominantly base metal	224	250	250	250	175	125	375	283	15
D6252	pontic – resin with noble metal*	288	250	250	250	175	125	405	283	15
D6253	provisional pontic – further treatment or completion of diagnosis necessary prior to final impression	95	95	95	90	80	50	NTCV	NTCV	25
D6545	retainer – cast metal for resin bonded fixed prosthesis	128	125	115	110	95	75	NTCV	NTCV	10
D6548	retainer – porcelain/ceramic for resin bonded fixed prosthesis	375	375	350	325	315	275	NTCV	NTCV	10
D6549	resin retainer – for resin bonded fixed prosthesis	128	125	115	110	110	NOR	NTCV	NTCV	10
D6600	retainer inlay – porcelain/ceramic, two surfaces	150	325	270	270	195	145	NTCV	133	40
D6601	retainer inlay – porcelain/ceramic, three or more surfaces	175	325	270	270	195	145	NTCV	142	45
D6602	retainer inlay – cast high noble metal, two surfaces*	150	200	185	175	150	115	350	147	40
D6603	retainer inlay – cast high noble metal, three or more surfaces*	175	200	185	175	150	115	360	173	45
D6604	retainer inlay – cast predominantly base metal, two surfaces	150	200	185	175	150	115	255	95	40
D6605	retainer inlay – cast predominantly base metal, three or more surfaces	175	200	185	175	150	115	260	121	45
D6606	retainer inlay – cast noble metal, two surfaces*	150	200	185	175	150	115	350	119	40
D6607	retainer inlay – cast noble metal, three or more surfaces*	175	200	185	175	150	115	360	129	45

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D6608	retainer onlay – porcelain/ceramic, two surfaces	175	335	280	280	205	155	NTCV	145	45
D6609	retainer onlay – porcelain/ceramic, three or more surfaces	185	335	280	280	205	155	NTCV	152	50
D6610	retainer onlay – cast high noble metal, two surfaces*	200	200	185	175	150	115	NTCV	173	55
D6611	retainer onlay – cast high noble metal, three or more surfaces*	225	200	175	175	150	115	NTCV	186	60
D6612	retainer onlay – cast predominantly base metal, two surfaces	185	200	175	175	150	150	NTCV	121	50
D6613	retainer onlay – cast predominantly base metal, three or more surfaces	200	200	175	175	150	150	NTCV	133	55
D6614	retainer onlay – cast noble metal, two surfaces*	185	200	175	175	150	115	NTCV	129	50
D6615	retainer onlay – cast noble metal, three or more surfaces*	195	200	175	175	150	115	NTCV	138	50
D6624	retainer inlay – titanium*	175	305	250	250	175	125	NTCV	309	45
D6634	retainer onlay – titanium*	175	305	250	250	175	125	NTCV	309	75
D6710	retainer crown – indirect resin based composite	160	180	150	150	125	90	NTCV	NTCV	20
D6720	retainer crown – resin with high noble metal*	320	250	250	250	175	125	405	283	40
D6721	retainer crown – resin with predominantly base metal	240	250	250	250	175	125	375	283	30
D6722	retainer crown – resin with noble metal*	272	250	250	250	175	125	405	283	30
D6740	retainer crown – porcelain/ceramic	352	350	300	300	225	215	475	357	100
D6750	retainer crown – porcelain fused to high noble metal*	352	305	250	250	175	125	405	322	100
D6751	retainer crown – porcelain fused to predominantly base metal	256	305	250	250	175	125	375	322	90
D6752	retainer crown – porcelain fused to noble metal*	320	305	250	250	175	125	405	322	100
D6780	retainer crown – ¾ cast high noble metal*	304	305	250	250	175	125	405	309	95
D6781	retainer crown – ¾ cast predominantly base metal	288	305	250	250	175	125	405	261	90
D6782	retainer crown – ¾ cast noble metal*	290	305	250	250	175	125	405	267	95
D6783	retainer crown – ¾ porcelain/ceramic	352	305	250	300	175	175	NTCV	272	95
D6790	retainer crown – full cast high noble metal*	304	305	250	250	175	125	405	309	100
D6791	retainer crown – full cast predominantly base metal	240	305	250	250	175	125	NTCV	309	90
D6792	retainer crown – full cast noble metal*	272	305	250	250	175	125	405	309	100
D6794	retainer crown – titanium*	304	305	250	250	175	125	405	309	100
D6930	re-cement or re-bond fixed partial denture	32	10	0	0	0	0	35	41	5
D6940	stress breaker	80	150	125	125	50	110	80	150	5
D6980	fixed partial denture repair necessitated by restorative material failure	80	80	75	75	70	50	80	NTCV	20
X. ORAL AND MAXILLOFACIAL SURGERY: Nonsurgical and surgical extractions (including sutures, if necessary) and related procedures; includes pre-op and post-op evaluations and treatment under local anesthetic										
D7111	extraction, coronal remnants – primary tooth	21	10	10	8	0	0	30	96	5
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	32	15	10	8	0	0	40	35	5
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	64	50	30	30	25	15	70	79	5
D7220	removal of impacted tooth – soft tissue	112	65	65	55	50	25	110	101	10
D7230	removal of impacted tooth – partially bony	128	95	85	85	75	50	190	105	20
D7240	removal of impacted tooth – completely bony	160	135	125	125	115	75	210	138	15
D7241	removal of impacted tooth – completely bony, with unusual surgical complications	176	155	150	150	135	90	230	131	25
D7250	removal of residual tooth roots (cutting procedure)	64	40	40	40	40	0	75	90	5
D7261	primary closure of a sinus perforation	105	105	0	0	0	0	NTCV	NTCV	10
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	102	80	50	50	50	50	NTCV	124	10

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UNITEDHEALTHCARE / NEVADA PACIFIC DENTAL
SELECT MANAGED CARE - DIRECT COMPENSATION PLANS
PRINCIPAL BENEFITS AND COVERAGES - MEMBER COPAYMENT SCHEDULE
EXHIBIT 2B

CDT CODE	CDT DESCRIPTION / PLAN NAME	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500	D1093 Southwest Carpenters Health
D7280	exposure of an unerupted tooth	160	120	85	85	85	85	NTCV	64	10
D7282	mobilization of erupted or malpositioned tooth to aid eruption	55	120	90	90	90	85	NTCV	43	5
D7285	incisional biopsy of oral tissue – hard (bone, tooth)	80	150	150	150	0	0	NTCV	169	5
D7286	incisional biopsy of oral tissue – soft	80	60	60	60	0	0	125	150	5
D7288	brush biopsy – transepithelial sample collection	40	0	0	0	0	0	NTCV		5
D7290	surgical repositioning of teeth	115	0	0	0	0	0	NTCV	NTCV	10
D7296	corticotomy - one to three teeth or tooth spaces, per quadrant	115	0	0	0	0	0	NTCV	NTCV	NTCV
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	115	0	0	0	0	0	NTCV	NTCV	NTCV
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	67	60	40	40	25	0	150	72	5
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	44	45	15	15	10	0	150	44	5
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	85	80	60	60	40	0	200	72	10
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	56	60	25	25	20	0	200	35	5
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	175	175	175	175	165	125	NTCV	NTCV	20
D7451	removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	275	200	200	200	175	150	NTCV	NTCV	30
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	185	185	185	185	165	135	NTCV	NTCV	20
D7461	removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	295	295	295	295	275	225	NTCV	NTCV	30
D7471	removal of lateral exostosis (maxilla or mandible)	165	100	85	85	75	75	NTCV	150	15
D7472	removal of torus palatinus	275	100	65	65	50	25	NTCV	152	30
D7473	removal of torus mandibularis	165	100	65	65	50	25	NTCV	134	15
D7485	reduction of osseous tuberosity	225	100	65	65	50	25	NTCV	171	25
D7510	incision and drainage of abscess – intraoral soft tissue	64	40	35	35	25	15	45	50	5
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	64	60	35	35	25	15	NTCV	50	5
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	80	80	80	80	80	80	NTCV	NTCV	5
D7881	occlusal orthotic device adjustment	160	15	10	10	10	0	22	20	NTCV
D7910	suture of recent small wounds up to 5 cm	20	25	25	25	25	15	NTCV	35	0
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	64	90	45	45	25	0	160	109	5
D7963	frenuloplasty	64	90	45	45	25	0	NTCV	85	5
D7970	excision of hyperplastic tissue – per arch	80	55	55	55	35	25	NTCV	456	10
D7971	excision of pericoronal gingiva	72	40	40	40	30	20	NTCV	224	10
D7972	surgical reduction of fibrous tuberosity	175	100	100	100	100	40	NTCV	110	20
XI. ORTHODONTICS: Orthodontic treatment; related procedures to improve a patient's craniofacial dysfunction and/or dentofacial deformity										
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition (24 Month Case)	N/A	2,900	2,900	2,900	2,900	2,900	3,100	3,304	1,000
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (24 Month Case)	N/A	2,900	2,900	2,900	2,900	2,900	3,100	3,304	1,000
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition (24 Month Case)	N/A	3,050	3,050	3,050	3,050	3,050	3,100	3,658	1,000
D8660	Pre-Orthodontic Treatment Visit (Orthodontic Consultation)	N/A	NTCV	NTCV	NTCV	NTCV	NTCV	0	NTCV	NTCV
D8670	Periodic Orthodontic Treatment (In Conjunction With Comprehensive Orthodontic Treatment)	N/A	0	0	0	0	0	0	0	0

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UNITEDHEALTHCARE / NEVADA PACIFIC DENTAL
SELECT MANAGED CARE - DIRECT COMPENSATION PLANS
PRINCIPAL BENEFITS AND COVERAGES - MEMBER COPAYMENT SCHEDULE
EXHIBIT 2B

CDT CODE	CDT DESCRIPTION / PLAN NAME	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500	D1093 Southwest Carpenters Health
D8680	Orthodontic Retention - Per Arch (Removal of Appliances, Construction and Placement of Retainers (s)	N/A	150	150	150	150	150	250	412	150
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	N/A	150	150	150	150	150	250	412	NTCV
D8999	Start Up Fee	N/A	250	250	250	250	250	150	150	350
D8999a	Post Treatment Records	N/A	NTCV	NTCV	NTCV	NTCV	NTCV	NTCV	150	350
XII. ADJUNCTIVE GENERAL SERVICES										
D9110	fixed partial denture sectioning	26	10	10	10	10	5	35	33	5
D9120	local anesthesia not in conjunction with operative or surgical procedures	39	0	0	0	0	0	NTCV	NTCV	15
D9210	regional block anesthesia	10	0	0	0	0	0	NTCV	NTCV	0
D9211	trigeminal division block anesthesia	15	0	0	0	0	0	NTCV	0	0
D9212	local anesthesia in conjunction with operative or surgical procedures	20	0	0	0	0	0	NTCV	0	0
D9215	inhalation of nitrous oxide/anxiolysis, analgesia	8	0	0	0	0	0	NTCV	0	0
D9219	evaluation for deep sedation or general anesthesia	0 [1]	25	0	0	0	NTCV	70	34	0
D9222	deep sedation/general anesthesia – first 15 minutes	125	75	75	75	75	75	70	55	10
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment	125	75	75	75	75	75	NTCV	55	5
D9230	non-intravenous conscious sedation	35	35	35	35	35	35	NTCV	NTCV	5
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	70	70	70	70	70	70	NTCV	70	10
D9243	intravenous moderate (conscious) sedation/anesthesia – each subsequent 15 minute increment	70	70	70	70	70	70	NTCV	70	5
D9248	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	50	50	50	50	40	35	NTCV	NTCV	5
D9310	office visit – after regularly scheduled hours	48	25	0	0	0	0	10	34	0
D9311	consultation with a medical health care professional	19	5	5	5	5	5	10	NTCV	NTCV
D9430	office visit for observation (during regularly scheduled hours) – no other services performed	19	5	5	5	5	5	70	NTCV	0
D9440	case presentation, detailed and extensive treatment planning	48	35	35	35	35	35	40	50	5
D9450	treatment of complications (post-surgical) – unusual circumstances, by report	0 [1]	0	0	0	0	0	0	0	NTCV
D9930	occlusal guard, by report	19	0	0	0	0	0	NTCV	0	0
D9932	cleaning and inspection of removable complete denture, maxillary	0	55	55	55	55	NTCV	NTCV	NTCV	NTCV
D9933	cleaning and inspection of removable complete denture, mandibular	0	55	55	55	55	NTCV	NTCV	NTCV	NTCV
D9934	cleaning and inspection of removable partial denture, maxillary	0	55	55	55	55	NTCV	22	NTCV	NTCV
D9935	cleaning and inspection of removable partial denture, mandibular	0	55	55	55	55	NTCV	NTCV	NTCV	NTCV
D9943	occlusal guard adjustment	16	15	10	10	10	0	NTCV	20	5
D9944	occlusal guard – hard appliance, full arch	75	120	100	85	85	85	NTCV	185	15
D9945	occlusal guard – soft appliance, full arch	75	120	100	85	85	85	NTCV	185	15
D9946	occlusal guard – hard appliance, partial arch	75	120	100	85	85	85	NTCV	185	15
D9951	occlusal adjustment – complete	40	35	35	30	30	0	40	37	5
D9952	external bleaching – per arch – performed in office	96	100	90	90	80	0	175	148	5
D9972	external bleaching for home application, per arch; includes materials and fabrication of custom trays	0 [1]	125	125	125	125	125	NTCV	NTCV	125
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays	0 [1]	125	125	125	125	125	NTCV	NTCV	NTCV
D9995	teledentistry – synchronous; real-time encounter	0 [1]	0	0	0	0	0	0	0	0

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UNITEDHEALTHCARE / NEVADA PACIFIC DENTAL
SELECT MANAGED CARE - DIRECT COMPENSATION PLANS
PRINCIPAL BENEFITS AND COVERAGES - MEMBER COPAYMENT SCHEDULE
EXHIBIT 2B

CDT CODE	CDT DESCRIPTION / PLAN NAME	RVU Fees	NV10-I NV10-I-5C NV10-I-10C	NV20-I NV20-I-5C NV20-I-10C	NV30-I NV30-I-5C NV30-I-10C	NV40-I NV40-I-5C NV40-I-10C	NV50-I NV50-I-10C NV50-I-10C	NV Individual 1000	DHMO NV 500	D1093 Southwest Carpenters Health
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0 [1]	0	0	0	0	0	0	0	0
D9999	unspecified adjunctive procedure, by report	0 [1]	20	20	20	10	10	10	20	NTCV

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

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UNITEDHEALTHCARE / NEVADA PACIFIC DENTAL
SELECT MANAGED CARE - DIRECT COMPENSATION PLANS
GENERAL LIMITATIONS AND EXCLUSIONS

LIMITATION 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 calendar year.
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 Covered Dental 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. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
23. Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.

UNITEDHEALTHCARE / NEVADA PACIFIC DENTAL
SELECT MANAGED CARE - INDIVIDUAL DIRECT COMPENSATION PLAN
LIMITATIONS AND EXCLUSIONS

LIMITATION OF BENEFITS:

The following are the limitation of benefi ts, unless otherwise specifically listed as a covered benefi t on this Plan's Schedule of Benefits:

1. Full Mouth X-rays - These are limited to only once in a 24 month period.
2. Bitewing X-rays - These are limited to one series every six months.
3. Fillings (amalgams and composites) are benefi ts for the removal of decay, for minor repairs of tooth structure or to replace a lost or failing restoration.
4. The placement of a crown, inlay or onlay is a benefit only when covered in the Schedule of Benefi ts and when there is insuffi cient tooth structure to support a filling. Veneers, posterior to the second bicuspid, are considered purely cosmetic dentistry. Allowances will be made for a cast full crown. If performed the Covered Person must pay the additional fee.
5. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
   a) The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and
   b) Either of the following:
   --The existing non-functional restoration /bridge/denture was placed five or more years prior to its replacement, or
   --If an existing partial denture is less than fi ve years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
6. Coverage for the placement of a fi xed partial denture (bridge) requires that:
   a) No cantilevered posterior pontic (prosthetic tooth) be included; and
   b) The sole tooth to be replaced in the arch is a permanent tooth, which cannot be replaced by adding another tooth to an existing removable partial denture; or
   --The new bridge would replace an existing, non-functional bridge; or
   --Each abutment tooth be crowned meets Limitation 4.
7. Fluoride Treatments - These are limited to only per year, to the age of 19.
8. Periodontal Curettage & Root Planing - Both of these procedures are allowable only when the need can be demonstrated radiographically and/or by written explanation and only two quadrants is allowable at an appointment with a maximum of four quadrants during any 12 consecutive months.
9. Benefi ts provided by a pediatric dentist are limited to children through age six following an attempt by the Covered Person's Participating Dentist to treat the child, and upon prior authorization, less applicable copayments. The plan will consider exceptions on an individual basis if a child has a physical or mental impairment, limitation or condition which substantially interferes with that child's ability to have Benefi ts provided by a Participating Dentist.
10. Relines - Limited to only twice per year.
11. Prophylaxis - These "teeth cleaning" are allowable only once every 6 months.
12. Replacement of Missing Teeth - With complete or partial dentures or fixed bridges, using standard procedures is covered. However, treatment involving the following procedures is considered optional and, if performed, Covered Person's should be advised of his/her responsibility for the additional fee:
    a) precious metal for removable appliances;
    b) precision attachments
    c) overlays and implants; and
    d) personalization and characterization
13. Correction of Occlusion - This is not a separate benefit, but it is considered a part of the completed restoration or fixed prosthesis.
14. Dowell Posts or PINS - These items are not covered, except where insufficient coronal structure remain to retain the crown restoration.
15. Subgingival Scaling - This procedure is allowable only when the need can be demonstrated.

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LIMITATIONS AND EXCLUSIONS

EXCLUSION OF BENEFITS:

1. Dental Services that are not Necessary.
2. Costs for non-Dental Services related to the provision of Dental Services in hospitals, extended care facilities, or Contract holder's home. When deemed Necessary by the Participating Dentist, the Contract holder'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 Dental Services Hospital and medical charges of any kind, except for dental services otherwise covered.
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 offi ce 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 and implants, implant crowns , implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to Dentist 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 Covered under the Contract.
16. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fi xed 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 Dentist 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's 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.
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 benefi ts under the plan. Inlays, onlays and fi xed 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).
36. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
37. Duplication of x-rays.
38. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.
39. Porcelain crowns, porcelain fused to metal or resin with metal type crown and fi xed partial denture (bridges) for children under 16 years of age.

UNITEDHEALTHCARE / NEVADA PACIFIC DENTAL
SELECT MANAGED CARE - SOUTHWEST CARPENTERS HEALTH DIRECT COMPENSATION PLAN
LIMITATIONS AND EXCLUSIONS

LIMITATION 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. **FLUORIDE TREATMENTS** - Limited to 1 time per 6 months.
3. **INLAYS, ONLAYS, AND VENEERS** - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
4. **CROWNS** - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
5. **POST AND CORES** - Covered only for teeth that have had root canal therapy.
6. **SCALING AND ROOT PLANING** - Limited to 4 quadrants per calendar year.
7. **REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROTHESIS** - Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implants, implant crowns, implant prosthesis previously submitted for payment under the plan is limited to 1 time per tooth per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances. 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.
8. **INTRAORAL BITEWING RADIOGRAPHS** - Limited to 1 series of 4 films in any 6 month period.
9. **STAINLESS STEEL CROWNS** - Limited to 1 time per tooth per 60 Months. Covered only when a filing cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary
10. **ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS** - Limited to repairs or adjustments performed more than 6 months after the initial insertion.
11. **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).
12. **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.
13. **PERIODONTAL MAINTENANCE PROCEDURES** - Limited to once every 6 months, following active therapy, exclusive of gross debridement.
14. **REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (MINOR 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.
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 Changes.
16. **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.

17. **INTRAORAL** - Complete Series (including bitewings) - Limited to 1 time in any 2-year period.
18. **TEMPORARY CROWNS** - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
19. **CONE BEAM** - Limited to 1 time per consecutive 60 months.

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 service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
3. Any Dental Procedure not directly associated with dental disease.
4. Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
5. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
6. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
7. 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.
8. 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.
9. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
10. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
11. 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.
12. 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.
13. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
14. 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.
15. 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.
16. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
17. 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.
18. Any Dental Procedure not performed in a dental setting. This will not apply to Covered Emergency Dental Services.
19. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
20. 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.
21. Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.
22. **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.

    Orthodontic Exclusions:

    a) Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
    b) Treatment in progress prior to the effective date of this coverage

c) Extractions required for orthodontic purposes
d) Surgical orthodontics or jaw repositioning
e) Myofunctional therapy
f) Cleft palate
g) Micrognathia
h) Macroglossia
i) Hormonal imbalances
j) Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of treatment of accident
k) Palatal expansion appliances
l) Services performed by outside laboratories

Orthodontic Limitations:

1. If a treatment plan is for less than 24 months, then a prorated portion of the full copayment shall apply.
2. 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
3. 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.
4. 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.

ORTHODONTIC LIMITATIONS AND EXCLUSIONS:

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:
   a) Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
   b) Treatment in progress prior to the effective date of this coverage
   c) Extractions required for orthodontic purposes
   d) Surgical orthodontics or jaw repositioning
   e) Myofunctional therapy
   f) Cleft palate
   g) Micrognathia
   h) Macroglossia
   i) Hormonal imbalances
   j) Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of treatment of accident
   k) Palatal expansion appliances
   l) 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.

OPTIONAL, UPGRADED OR ALTERNATIVE TREATMENT DISCLOSURE FORM

Patient's Name:	ID:	UnitedHealthcare®
Treatment Plan No.:		Chart ID No.:

I. FORMULA for DETERMINING CHARGES for OPTIONAL, UPGRADED or ALTERNATIVE TREATMENT:

When a Member elects a more extensive service that is an alternative to an adequate, but more conservative covered service, please use the following formula to determine the charge:

UCR Fee of Proposed Upgrade [1] - UCR Fee of the Benefit [2] + Copayment for the Benefit [3] = Accepted Charge for the Proposed Upgrade [4]

			1	2	3	4
CDT Code of Proposed Treatment	Proposed Procedure Description (Indicate reason this is not covered in explanation area below*)	Tooth No. or Area	UCR Fee of Upgrade	UCR Fee of Benefit	Copayment of Benefit	[1] - [2] + [3] = Accepted Charge

II. METAL UPGRADES (for crowns, bridge abutments & pontics)

When a Member elects a laboratory upgrade of a standard covered service, please use the following formula to determine the charge:

Some plans only allow a metal laboratory upgrade charge (e.g. Blue Shield 65 Plus, plans with version 5 Limitations). Metal Upgrades are based on the additional cost of the metal. In these instances please use the following formula to determine the charge:

Copayment [1] + Metal Upgrade [2] = Accepted fee [3]

				1	2	3
CDT Code of Proposed Treatment	Proposed Procedure Description	Tooth No. or Area	UCR Fee of Proposed Treatment	Copayment of Benefit	Additional Charge for Metal Upgrade	Accepted Charge

*Reason for Upgrade / Reason proposed service is not covered:

I agree to the above charges which represent additional financial obligations for treatment or features that I desire that are not part of my dental benefit plan.

Patient's (Parent or Guardian) Signature:	Date:
Treatment Plan presented by DDS:	Date: