UnitedHealthcare® DHMO/Contributory 110/covered dental services

TX D099N

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0405	DISEASES - SPECIMEN ANALYSIS	00
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$12
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0472	REPORT	Φ0
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	\$0
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	ΨΟ
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	CARIES RISK ASSESSMENT AND	\$0
	IMAGE			DOCUMENTATION, LOW	**
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
D0040	RADIOGRAPHIC IMAGE	Φ0		DOCUMENTATION, MODERATE	
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
D0251	IMAGE	\$0	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$5
D0231	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	ΨΟ		CAPTURE ONLY	
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$5
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	IMAGE CAPTURE ONLY	40
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	\$0
D0277		\$0	D0700	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE- IMAGE CAPTURE ONLY	ΨΟ
DOZII	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	ΨΟ	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$5		IMAGE-IMAGE CAPTURE ONLY	**
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	\$0
	ACQUISITION, MEASUREMENT AND ANALYSIS	,		IMAGE CAPTURE ONLY	
D0364	CONE BEAM CT CAPTURE AND	\$30	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
	INTERPRETATION WITH LIMITED FIELD OF			RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	
	VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$0
D0365	CONE BEAM CT CAPTURE AND	\$30	PREVEN	ITIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D1110 ¹	PROPHYLAXIS - ADULT	\$5
Doocc	OF ONE FULL DENTAL ARCH-MANDIBLE	¢οσ	D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$35		6 MONTHS	
	INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA		D11201	PROPHYLAXIS - CHILD	\$5
D0367	CONE BEAM CT CAPTURE AND	\$35	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
2000.	INTERPRETATION WITH FIELD OF VIEW OF BOTH	400	D. 4.0.0.0	MONTHS	^-
	JAWS		D1206	TOPICALFLUORIDE VARNISH	\$5
D0368	CONE BEAM CT CAPTURE AND	\$35	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
	INTERPRETATION FOR TMJ SERIES INCLUDING		D4240	EXCLUDING VARNISH	ΦO
	TWO OR MORE EXPOSURES		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0 \$10
	SPECIMEN TO INCLUDE CULTURE AND		D1351	SEALANT - PER TOOTH	\$10
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
D0415	TRANSMISSION OF WRITTEN REPORT COLLECT MICROORGANISMS CULT & SENS	\$0	D43E3	CARIES RISK PATIENT- PERM TOOTH	¢۲
			D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10 \$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION – PER TOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$305
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$35	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$305
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$35	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$305
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$45	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$305
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$45	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$305
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$45	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$305
D1551	RECEM/REBOND BILATERAL SPACE	\$15	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$180
	MAINTAINER – MAXIL		D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$180
D1552	RECEM/REBOND BILATERAL SPACE	\$15	D0700*	INDIRECT	#050 *
D1553	MAINTAINER – MANDIB RECEM/REBOND UNILATERAL SPACE	\$15	D2720* D2721	CROWN - RESIN WITH HIGH NOBLE METAL	\$250* \$250*
D 1000	MAINTAINER/QUAD	ψio	D2721 D2722*	CROWN - RESIN W/PREDOM BASE METAL CROWN - RESIN WITH NOBLE METAL	\$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2722 D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$250* \$350*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$305*
D1557	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$305*
D1558	MAINTAINER-MAXIL	\$15		METAL METAL	,,,,
וטטסס	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	\$10	D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$305*
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED.	\$30	D2753	CROWN PORCELAIN FUSED TO	\$305
	UNILATERAL/QUAD			TITANIUM/TITANIUM ALLOYS	***
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$0	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$305*
DECTOR	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$305*
	ATIVE SERVICES	A 4-	D2782*	CROWN - 3/4 CAST NOBLE METAL	\$305*
D2140	AMALGAM - ONE SURFACE	\$15	D2783 D2790*	CROWN - 3/4 PORCELAIN/CERAMIC CROWN - FULL CAST HIGH NOBLE METAL	\$305* \$305*
D2150	PRIMARY/PERMANENT AMALGAM - TWO SURFACES	\$20	D2790 D2791	CROWN - FULL CAST FIREDOM BASE METAL	\$305*
DETOO	PRIMARY/PERMANENT	\$25	D2791*	CROWN - FULL CAST NOBLE METAL	\$305*
D2160	AMALGAM - 3 SURFACES	\$25	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$305*
D2161	PRIMARY/PERMAMENT AMALGAM - FOUR/MORE SURFACES	\$30	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$10
	PRIMARY/PERMANENT		D2915	OR PART COV REST RECEMENT OR RE-BOND INDIRECTLY	\$10
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$20	52010	FABRICATED PREFABRICATED POST & CORE	Ψισ
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$25	D2920	RECEMENT OR RE-BOND CROWN	\$10
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$30	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$40	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$70	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$60
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$65		PRIMARY	
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$85	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$60
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$105 \$100	D2932	PERMANENT PREFABRICATED RESIN CROWN	\$45
D2394 D2510	RESIN COMPOSITE - 4/MORE SURFACES POST INLAY - METALLIC - ONE SURFACE	\$120 \$200	D2932		\$60
D2510	INLAY - METALLIC - ONE SURFACE INLAY - METALLIC - TWO SURFACES	\$200 \$200	D2333	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	ψΟΟ
D2530	INLAY - METALLIC - 1/WO SURFACES	\$200	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$250 \$250		STEEL CROWN - PRIMARY	
D2543	ONLAY - METALLIC THREE SURFACES	\$250	D2940	SEDATIVE FILLING	\$10
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$250 \$250	D2941	INTERIM THERAPEUTIC RESTORATION -	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$305*	D0050	PRIMARY DENTITION	A-7 0
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$305*	D2950	CORE BUILDUP INCLUDING ANY PINS DIN DETENTION DEP TOOTH ADDITION DEST	\$70 \$15
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$305*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$15 \$50
	SURFACES	·	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$50 \$50
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$305*	D2953	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	\$50
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$305*	D2954	PREFABRICATED POST & CORE ADDITION	\$30
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	\$305*	-	CROWN	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
				MOLAR	
D2962	LABIAL VENEER (PORCELAIN LAMINATE) -	\$600*	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$25
D2971	INDIRECT	\$50	D3911	INTRAORIFICE BARRIER	\$65
DZ311	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER XST PART DENTURE	ΨΟΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	OONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$150
B2000	SURFACE LESIONS	Ψ		TEETH QUAD	
ENDODO	ONTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$95
D3110	PULP CAP - DIRECT	\$5		TEETH QUAD	
D3120	PULP CAP - INDIRECT	\$5	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3220		\$25		PROC/TOOTH	
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL JUNC	Ψ23	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$160
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$55	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$115
2022.	TEETH	400	D4245	APICALLY POSITIONED FLAP	\$175
D3222	PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$175
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$385
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$300
B0210	TOOTH	Ψ10	D4263	BONE REPLACEMENT GRAFT - RETAINED	\$235
D3310	ANTERIOR	\$125		NATURAL TOOTH - FIRST SITE IN QUADRANT	
D3320	BICUSPID	\$215	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3330	MOLAR	\$365		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$115		QUADRANT	
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$115	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$255
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$115	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$100
D3346		\$115 \$155		TOOTH (WHEN NOT PERFORMED IN	
	RETX PREVIOUS RC THERAPY - ANTERIOR	•		CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$245	D4277	IN THE SAME ANATOMICAL AREA)	\$235
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$415	D4211	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	φ233
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	2.2.0	TOOTH	V 2.0
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70	D4322	SPLINT-INTRA-CORONAL: NATURAL TEETH OR	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65		PROSTHETIC CROWNS	
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
	MEDICAMENT REPLACEMENT			PROSTHETIC CROWNS	
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4341	PERIODONTAL SCAL & ROOT PLAN	\$55t
D2440	TREATMENT	Ф44 Г		4/>TEETH-QUAD	
D3410	APICOECTOMY SURG - ANT	\$115	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$55t
D3421	APICOECTOMY SURG-BICUSPID	\$125	D4346	SCALING IN PRESENCE OF GENERALIZED	\$30
D3425	APICOECTOMY SURG - MOLAR	\$140		MODERATE OR SEVERE GINGIVAL	
D3426	APICOECTOMY SURGERY	\$95		INFLAMMATION – FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$60	D. 40==	EVALUATION	A :
D3450	ROOT AMPUTATION - PER ROOT	\$110	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$55t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900	D4381	ON A SUBSEQUENT VISIT	\$65t
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	\$115	D4361	AGENTS VIA A CONTROLLED RELEASE VEHICLE	φυσι
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR	\$125	D4040	INTO DISEASED CREVICULAR TISSUE, PER TOOTH	* 40
D3473	SURGICAL REPAIR OF ROOT RESORPTION -	\$140	D4910	PERIODONTAL MAINTENANCE	\$40
	MOLAR		D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
	APICOECTOMY OR REPAIR ROOT		REMOV D5110	ABLE PROSTHODONTIC SERVICES COMPLETE DENTURE - MAXILLARY	\$425*
	RESORPT-ANTERIOR		טווטע	OUNTELLE DENTURE - WAAILLART	Φ42 3"

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$50*
D5120	COMPLETE DENTURE - MANDIBULAR	\$425*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$440*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$165*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$440*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$400*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$165*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$400*	DE740	MANDIBULAR	¢40г*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$450*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$105*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$450*	D5711	REBASE COMPLETE MANDIBULAR DENTURE REBASE MAXILLARY PARTIAL DENTURE	\$105* \$105*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$145*	D5720 D5721	REBASE MANDIBULAR PARTIAL DENTURE	\$105 \$105*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$105 \$105
	MATERIALS, RESTS AND TEETH)		D5725	RELINE CMPL MAXIL DENTURE (DIRECT)	\$105 \$90*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$155*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$90*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$90*
D5223	MATERIALS, RESTS AND TEETH)	\$145*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$90*
DOZZO	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ψ14 0	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$115*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$115*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$115*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$115*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$155*	D5765	SOFT LINER FOR COMPLETE OR PART	\$35
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	φοσ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$160*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$170*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$450*	D5850	TISSUE CONDITIONING MAXILLARY	\$35
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$450*	D5851	TISSUE CONDITIONING MANDIBULAR	\$35
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$145	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$155	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE		D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$330*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$105
D5283	MAXILLARY	\$330*		DENTURE (PER ARCH)	
D0200	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	ΨΟΟΟ	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$450	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	****
D5286	REMOVABLE UNILATERAL PARTIAL	\$450	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$15	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$15	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖ13
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$15	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$15		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$40*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$40*		CROWN	
D5520	MAXILLARY	\$40*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	Ψ40	DCCC	METAL CROWN (HIGH NOBLE METAL)	PC40
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$40*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$40*		METAL CROWN (NOBLE METAL)	****
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$40*		(HIGH NOBLE METAL)	
DEGOO	MANDIBULAR	#40*	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$40*	D0004	(PREDOMINATELY BASE METAL)	4-4-
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$40*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
_ 5550	TOOTH	Ψ.0	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$40*	50000	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	ΨΟΟΟ
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$40*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	, , , ,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)		20.02	DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	ΨΞ. ΰ
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D6070*	METAL)	¢ 625	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH –	
D6073	METAL FPD (HIGH NOBLE METAL) ABUTMENT SUPPORTED RETAINER FOR CAST	\$595	D6111	MAXILLARY	\$875
20010	METAL FPD (PREDOMINATELY BASE METAL)	φοσο	DOTTI	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH –	φοισ
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		MANDIBULAR	
	METAL FPD (NOBLE METAL)		D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630	D0400	– MANDIBULAR	# 000
D6080	FPD - HIGH NOBLE ALLOYS	\$40	D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D0000	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED.	Ψ40	D6121	TO TITANIUM/TITANIUM ALLOYS IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND		BOILI	FPD-PREDOM. BASE ALLOYS	4000
	ABUTMENTS		D6122	IMPLANT SUPPT RETAINER FOR METAL	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t		FPD-NOBLE ALLOYS	
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE		D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE		D0400	FPD-TITANIUM/TITANIUM ALLOYS	A.1.5
	IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	REPORT SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
	PREDOM. BASE ALLOYS	,	D6191	SEMI-PRECISION ATTACHMENT - PLACEMENT	\$220
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6194		\$545
	NOBLE ALLOYS		D0104	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	φυτυ
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
DCCCC	TITANIUM/TITANIUM ALLOYS	0.70		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$305*
D0000	ALLOYS	ΨΟΙΟ	D6211	PONTIC - CAST PREDOM BASE METAL	\$305*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$305*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$305*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$305*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$305*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
D6092	ATTCHMT	\$60	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$305*
D0092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	φου	D6243	PONTIC-PORCELAIN FUSED TO	\$305*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	DC045	TITANIUM/TITANIUM ALLOYS	# 0F0*
	SUPPORTED FIXED PARTIAL DENTURE	4.5	D6245	PONTIC - PORCELAIN/CERAMIC	\$350* \$250*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250* \$250*
	AND TITANIUM ALLOYS		D6251 D6252*	PONTIC RESIN W/PREDOM BASE METAL	\$250* \$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D0252°	PONTIC RESIN W/NOBLE METAL	\$250*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED PI	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$305*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$305*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	D.0=0.0÷	BASE METAL	200 74
D0540	PROSTHESIS	#200 *	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$305*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$305* \$305*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED	\$85		RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	
D6600	PROSTHESIS RETAINER INLAY - PORCELAIN/CERAMIC 2	\$325*	D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	\$305*
D6601	SURFACES	\$325*	D6791	RETAINER CROWN - FULL CAST	\$305*
D0001	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	φ323	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$305*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2	\$200*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$305*
	SURFACES			ALLOYS	
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$200*	D6920	CONNECTOR BAR	\$85
D6604	SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$200*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL	\$10
2000.	2 SURFACES	4 200	D6940	DENTURE STRESS BREAKER	\$150
D6605	RETAINER INLAY - CAST PREDOM BASE METAL	\$200*	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$60
D0000+	3/>SURFACES	4000*		URGERY SERVICES	***
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$200*	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$10
D6607*	SURFACES RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$200*	D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$15
	SURFACES		D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$50
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$335*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$335*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$65
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2	\$200*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$95
	SURFACES		D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$135
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/>	\$200*	D7241	BONY	\$155
D6612	SURFACES RETAINER ONLAY - CAST PREDOM BASE METAL	\$200*		REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	·
D6612	2 SURFACES	\$200*	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS	\$40
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$200*	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$200*		REMOVAL	****
	SURFACES		D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL	\$200*	D7270	TOOTH REIMPLANTATION AND/OR	\$80
D6624*	3/MORE SURFACES RETAINER INLAY - TITANIUM	\$305*	D7000	STABILIZATION ACCIDENTLY DISPLACED EXPOSURE OF AN UNERUPTED TOOTH	¢120
D6634*	RETAINER ONLAY - TITANIUM	\$305*	D7280 D7282		\$120 \$120
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D1202	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	φ120
	COMPOSITE	·	D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE	\$250*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$60
D0704	METAL	4050*	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	\$250*	D7000	COLLECTION	***
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$350*	D7290 D7310	SURGICAL REPOSITIONING OF TEETH ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	\$75 \$60
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$305*	D7310	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$45
	HIGH NOBLE METAL		D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$80
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$305*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$60
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$305*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
D0102	NOBLE METAL	ΨΟΟΟ		(SECONDARY EPITHELIALIZATION)	
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$305*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	URGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$120
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$120
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	# 400
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$120
D7460	1.25 CM REMOVAL OF BENIGN NONODONTOGENIC CYST	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$35
B1 100	OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$100
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
D7474	1.25 CM	6400	D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LODGE BALATINGS	\$100 \$100	DOOOL	APPLICATION, PER ARCH	40
D7472 D7473	REMOVAL OF TORUS PALATINUS REMOVAL OF TORUS MANDIBULARIS	\$100 \$100	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REDUCTION OF OSSEOUS TUBEROSITY	\$100 \$100	D9996	ENCOUNTER TELEDENTISTRY - ASYNCHRONOUS:	\$0
D7403	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$40	20000	INFORMATION STORED AND FORWARDED TO	Ψ*
D7510		\$60		DENTIST FOR SUBSEQUENT REVIEW	
DISTI	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	ΨΟΟ	D9999	BROKEN APPOINTMENT	\$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$15	D8090	ADOLESCENT DENTITION	\$1,895
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D0030	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	ψ1,030
D7961	BUCCAL / LABIAL FRENECTOMY	\$90	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
D7000	(FRENULECTOMY)	\$00		MONITOR GROWTH AND DEVELOPMENT	
D7962 D7963	LINGUAL FRENECTOMY (FRENULECTOMY)	\$90	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7903 D7970	FRENULOPLASTY EXC HYPERPLASTIC TISSUE-PER ARCH	\$90 \$55		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7971	EXCISION OF PERICORONAL GINGIVA	\$33 \$40	D8695	OF RETAINERS)	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	\$100	D0093	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF	φ130
	CTIVE GENERAL SERVICES	φίσσ		TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$25			
D9222	ANESTHESIA DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
50222	15 MINUTES	Ų.00			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	\$75			
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	\$30			
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	\$140			
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	\$70			
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	\$50			
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$25			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$15			

'Additional Prophy within 6 months will be based upon the necessity recommended by the provider.
'Copays listed are also applicable in the specialist office.

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

'If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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This plan is underwritten by National Pacific Dental, Inc.

UnitedHealthcare/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 Benefit

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		• Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

The following precedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered

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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
10.	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.
11.	Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
12.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
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. Covered Person by any municipality, county, or other political subdivision.

- This exclusion does not apply to any services covered by Medicaid or Medicare. 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 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.
- 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.
- Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Voluntary 110C/covered dental services

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ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0405	DISEASES - SPECIMEN ANALYSIS	Φ0
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$12
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0472	REPORT	¢ο
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	\$0
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	ΨΟ
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	CARIES RISK ASSESSMENT AND	\$0
	IMAGE		50001	DOCUMENTATION, LOW	Ψ
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
50040	RADIOGRAPHIC IMAGE	•		DOCUMENTATION, MODERATE	
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
D0054	IMAGE	# 0	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$5
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	
D0270	RADIOGRAPHIC IMAGE BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$5
D0270	BITEWINGS - TWO RADIOGRAPHIC IMAGES			IMAGE CAPTURE ONLY	
		\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0 \$0	D0700	RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	40
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0	D0707	IMAGE CAPTURE ONLY	\$0
D0330	IMAGES PANORAMIC RADIOGRAPHIC IMAGE	\$5	DOTOT	INTRAORAL-PERIAPICAL RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	φυ
D0340		\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	\$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	ΨΟ	20.00	IMAGE CAPTURE ONLY	ų.
D0364	CONE BEAM CT CAPTURE AND	\$30	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
20001	INTERPRETATION WITH LIMITED FIELD OF	400		RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	
	VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$5
D0365	CONE BEAM CT CAPTURE AND	\$30	PREVEN	ITIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D1110 ¹	PROPHYLAXIS - ADULT	\$5
	OF ONE FULL DENTAL ARCH-MANDIBLE		D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$35		6 MONTHS	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11201	PROPHYLAXIS - CHILD	\$5
D0007	OF ONE FULL DENTAL ARCH-MAXILLA	005	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
D0367	CONE BEAM CT CAPTURE AND	\$35		MONTHS	
	INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS		D1206	TOPICALFLUORIDE VARNISH	\$5
D0368	CONE BEAM CT CAPTURE AND	\$35	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
20000	INTERPRETATION FOR TMJ SERIES INCLUDING	400		EXCLUDING VARNISH	
	TWO OR MORE EXPOSURES		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
	SPECIMEN TO INCLUDE CULTURE AND		D1351	SEALANT - PER TOOTH	\$10
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
	TRANSMISSION OF WRITTEN REPORT			CARIES RISK PATIENT- PERM TOOTH	
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION - PER TOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$305
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$35	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$305
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$35	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$305
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$45	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$305
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$45	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$305
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$45	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$305
D1551	RECEM/REBOND BILATERAL SPACE	\$15	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$180
D4550	MAINTAINER – MAXIL	#45	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$180
D1552	RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB	\$15	D2720*	INDIRECT CROWN - RESIN WITH HIGH NOBLE METAL	\$250*
D1553	RECEM/REBOND UNILATERAL SPACE	\$15	D2720 D2721	CROWN - RESIN WITH HIGH NOBEL METAL CROWN - RESIN W/PREDOM BASE METAL	\$250*
	MAINTAINER/QUAD		D2722*	CROWN - RESIN WITH NOBLE METAL	\$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$350*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$305*
D1557	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$305*
D1558	MAINTAINER-MAXIL REMOVAL OF FIXED BILATERAL SPACE	\$15		METAL	
D 1000	MAINTAINER-MANDIB	Ψισ	D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$305*
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED,	\$30	D2753	CROWN PORCELAIN FUSED TO	\$305
	UNILATERAL/QUAD		D0700*	TITANIUM/TITANIUM ALLOYS	¢20E*
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$5	D2780* D2781	CROWN - 3/4 CAST HIGH NOBLE METAL CROWN - 3/4 CAST PREDOM BASE METAL	\$305* \$305*
DESTOR	REPORT ATIVE SERVICES		D2761 D2782*	CROWN - 3/4 CAST PREDOM BASE METAL CROWN - 3/4 CAST NOBLE METAL	\$305*
D2140		\$15	D2783	CROWN - 3/4 CAST NOBLE METAL CROWN - 3/4 PORCELAIN/CERAMIC	\$305*
DZ 140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	\$15	D2790*	CROWN - 5/41 ORCELAND CENSING CROWN - FULL CAST HIGH NOBLE METAL	\$305*
D2150	AMALGAM - TWO SURFACES	\$20	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$305*
	PRIMARY/PERMANENT	·	D2792*	CROWN - FULL CAST NOBLE METAL	\$305*
D2160	AMALGAM - 3 SURFACES	\$25	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$305*
D2161	PRIMARY/PERMAMENT AMALGAM - FOUR/MORE SURFACES	\$30	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	\$10
	PRIMARY/PERMANENT	•••	D2915	RECEMENT OR RE-BOND INDIRECTLY	\$10
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$20		FABRICATED PREFABRICATED POST & CORE	
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$25	D2920	RECEMENT OR RE-BOND CROWN	\$10
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$30	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$40	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390 D2391	RESIN COMPOSITE CROWN ANTERIOR RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$70 \$65	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$60
D2391	RESIN COMPOSITE - 1 SURFACES POSTERIOR	\$85	D0034	PRIMARY	ተ ርዕ
D2393	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$105	D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	\$60
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$120	D2932	PREFABRICATED RESIN CROWN	\$45
D2510	INLAY - METALLIC - ONE SURFACE	\$200	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$60
D2520	INLAY - METALLIC - TWO SURFACES	\$200		RESIN WINDOW	
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$200	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$250		STEEL CROWN - PRIMARY	
D2543	ONLAY - METALLIC THREE SURFACES	\$250	D2940	SEDATIVE FILLING	\$10
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$250	D2941	INTERIM THERAPEUTIC RESTORATION –	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$305*	D2950	PRIMARY DENTITION CORE BUILDUP INCLUDING ANY PINS	\$70
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$305*	D2950 D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$15
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$305*	D2951	POST & CORE ADD CROWN INDIRECT FAB	\$13 \$50
	SURFACES		D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$50 \$50
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$305*		TOOTH	400
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$305*	D2954	PREFABRICATED POST & CORE ADDITION	\$30
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$305*		CROWN	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962	LABIAL VENEER (PORCELAIN LAMINATE) -	\$600*	D2040	MOLAR	¢οσ
	INDIRECT	,	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$25
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$50	D3911	INTRAORIFICE BARRIER	\$65
	XST PART DENTURE		D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST CONTIC SERVICES	\$15
D2980	CROWN REPAIR	\$35			A 450
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$150
	SURFACE LESIONS		D4211	TEETH QUAD	\$95
	ONTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	ψ95
D3110	PULP CAP - DIRECT	\$5	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$5		PROC/TOOTH	***
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$25	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$160
D0004	JUNC	٨٥٦	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$115
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$55	D4245	APICALLY POSITIONED FLAP	\$175
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$175
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$385
D3240		\$40 \$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$300
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	Ψ40	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$235
D3310	ANTERIOR	\$125		NATURAL TOOTH - FIRST SITE IN QUADRANT	
D3320	BICUSPID	\$215	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3330	MOLAR	\$365		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$115	D 10=0	QUADRANT	***
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$115	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$255
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$115	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$100
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$155		TOOTH (WHEN NOT PERFORMED IN	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$245		CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$415	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70		TOOTH	
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70		ТООТН	
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	\$75
D3356		\$65		PROSTHETIC CROWNS	
D3330	PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT	ΨΟΟ	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4244	PROSTHETIC CROWNS	¢==+
	TREATMENT		D4341	PERIODONTAL SCAL & ROOT PLAN	\$55t
D3410	APICOECTOMY SURG - ANT	\$115	D4342	4/>TEETH-QUAD PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$55t
D3421	APICOECTOMY SURG-BICUSPID	\$125	D4346	SCALING IN PRESENCE OF GENERALIZED	\$30
D3425	APICOECTOMY SURG - MOLAR	\$140	Бчочо	MODERATE OR SEVERE GINGIVAL	φου
D3426	APICOECTOMY SURGERY	\$95		INFLAMMATION – FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$60		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$110	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$55t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900		ON A SUBSEQUENT VISIT	
D3471	SURGICAL REPAIR OF ROOT RESORPTION -	\$115	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL	\$65t
	ANTERIOR			AGENTS VIA A CONTROLLED RELEASE VEHICLE	
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$125		INTO DISEASED CREVICULAR TISSUE, PER	
	PREMOLAR		D4910	TOOTH PERIODONTAL MAINTENANCE	\$40
D3473	SURGICAL REPAIR OF ROOT RESORPTION -	\$140	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3E04	MOLAR	ΦΩΕΩ	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250		ABLE PROSTHODONTIC SERVICES	40
	APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$425*
	NEOONI I-MITENION		20110	JOIN EELE DEITIONE IN VICE IN	ΨτΔΟ

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$50*
D5120	COMPLETE DENTURE - MANDIBULAR	\$425*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$440*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$165*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$440*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$400*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$165*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$400*	DE740	MANDIBULAR	¢40г*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$450*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$105*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$450*	D5711	REBASE COMPLETE MANDIBULAR DENTURE REBASE MAXILLARY PARTIAL DENTURE	\$105* \$105*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$145*	D5720 D5721	REBASE MANDIBULAR PARTIAL DENTURE	\$105 \$105*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$105 \$105
	MATERIALS, RESTS AND TEETH)		D5725	RELINE CMPL MAXIL DENTURE (DIRECT)	\$105 \$90*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$155*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$90*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$90*
D5223	MATERIALS, RESTS AND TEETH)	\$145*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$90*
DOZZO	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ψ14 0	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$115*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$115*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$115*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$115*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$155*	D5765	SOFT LINER FOR COMPLETE OR PART	\$35
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	φοσ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$160*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$170*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$450*	D5850	TISSUE CONDITIONING MAXILLARY	\$35
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$450*	D5851	TISSUE CONDITIONING MANDIBULAR	\$35
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$145	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$155	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE		D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$330*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$105
D5283	MAXILLARY	\$330*		DENTURE (PER ARCH)	
D0200	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	ΨΟΟΟ	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$450	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	****
D5286	REMOVABLE UNILATERAL PARTIAL	\$450	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$15	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$15	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖ13
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$15	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$15		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$40*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$40*		CROWN	
D5520	MAXILLARY	\$40*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	Ψ40	DCCC	METAL CROWN (HIGH NOBLE METAL)	PC40
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$40*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$40*		METAL CROWN (NOBLE METAL)	****
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$40*		(HIGH NOBLE METAL)	
DEGOO	MANDIBULAR	#40*	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$40*	D0004	(PREDOMINATELY BASE METAL)	4-4-
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$40*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
_ 5550	TOOTH	Ψ.0	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$40*	50000	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	ΨΟΟΟ
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$40*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLAN	T SERVICES	-	D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)		D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	\$630	D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	\$275
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	\$245
D6072*	METAL) ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	\$635	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	\$875
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	\$595	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH –	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		MANDIBULAR	
D6075	METAL FPD (NOBLE METAL) IMPLANT SUPPORTED RETAINER FOR CERAMIC	\$615	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH	\$875
D6076*	FPD IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$680	D6113	- MAXILLARY IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	
D0000	FPD - HIGH NOBLE ALLOYS	040	D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND	\$40	D6121	TO TITANIUM/TITANIUM ALLOYS IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS	\$630
	ABUTMENTS		D6122	IMPLANT SUPPT RETAINER FOR METAL	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE	\$180t	D6123	FPD-NOBLE ALLOYS IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	FPD-TITANIUM/TITANIUM ALLOYS RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D6082	AND CLOSURE IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	REPORT SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
	PREDOM. BASE ALLOYS	****	D6191	SEMI-PRECISION ATTACHMENT - PLACEMENT	\$220
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS	\$660	D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	FUSED TO TITANIUM/TITANIUM ALLOYS PROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$305*
	ALLOYS		D6211	PONTIC - CAST PREDOM BASE METAL	\$305* \$305*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	\$165	D6212* D6214*	PONTIC - CAST NOBLE METAL PONTIC - TITANIUM AND TITANIUM ALLOYS	\$305* \$305*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$305*
	SEMI-PRECISION/PRECISION ATTCHMT OF IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	\$305*
DCCCC	ATTCHMT	400	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$305*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	\$60	D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$305*
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	\$70	D6245	PONTIC - PORCELAIN/CERAMIC	\$350*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$250* \$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$250*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED PI	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$305*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$305*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	D0700*	BASE METAL	***
D0540	PROSTHESIS	****	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$305*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$305* \$305*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED	\$85		RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	
D6600	PROSTHESIS RETAINER INLAY - PORCELAIN/CERAMIC 2	\$325*	D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	\$305*
D0004	SURFACES	#205 *	D6791	RETAINER CROWN - FULL CAST	\$305*
D6601	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$325*	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$305*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2	\$200*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$305*
	SURFACES			ALLOYS	
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$200*	D6920	CONNECTOR BAR	\$85
D6604	SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$200*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	\$10
	2 SURFACES		D6940	STRESS BREAKER	\$150
D6605	RETAINER INLAY - CAST PREDOM BASE METAL	\$200*	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$60
D6606*	3/>SURFACES RETAINER INLAY - CAST NOBLE METAL 2	\$200*	ORAL SI	JRGERY SERVICES	
20000	SURFACES	\$200	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$10
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$200*	D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$15
	SURFACES		D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$50
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$335*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$335*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$65
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2	\$200*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$95
D0044#	SURFACES	4000 *	D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$135
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$200*	D7241	BONY REMOVAL IMPACTED TOOTH - COMPLETELY	\$155
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	\$200*	D7250	BONY W/SURG COMP REMOVAL OF RESIDUAL TOOTH ROOTS	\$40
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL	\$200*		(CUTTING PROCEDURE)	
D0044*	3/>SURFACES	***	D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	\$200*	D7261	REMOVAL PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL	\$200*	D7270	TOOTH REIMPLANTATION AND/OR	\$80
	3/MORE SURFACES		2.2.0	STABILIZATION ACCIDENTLY DISPLACED	400
D6624*	RETAINER INLAY - TITANIUM	\$305*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$120
D6634*	RETAINER ONLAY - TITANIUM	\$305*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$120
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D6720*	COMPOSITE RETAINER CROWN - RESIN WITH HIGH NOBLE	\$250*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$150 \$60
20.20	METAL	4200	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$250*	51201	COLLECTION	Ψ20
	BASE METAL		D7288	BRUSH BIOPSY	\$20
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$350*	D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	\$60
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	\$305*	D7311 D7320	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$45 \$80
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$305*	D7320	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$60 \$60
	PREDOMINANTLY BASE METAL		D7321	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
D6752*	RETAINER CROWN - PORCELAIN FUSED TO	\$305*	21070	(SECONDARY EPITHELIALIZATION)	Ψ210
D6753	NOBLE METAL RETAINER CROWN-PORCELAIN FUSED TO	\$305*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
_ 0. 00	TITANIUM/TITANIUM ALLOYS	4000		(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$120
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	,
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$120
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110		ARCH	
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$120
	1.25 CM		D0054	ARCH	405
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$100	D9951	OCCLUSAL ADJUSTMENT - LIMITED	\$35
D7464	OR TUMOR - LESION DIAMETER UP TO 1.25 CM	¢10E	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$100
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM		D9975	PERFORMED IN OFFICE	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$100	D3313	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	Ψ123
D7472	REMOVAL OF TORUS PALATINUS	\$100	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$100		ENCOUNTER ENCOUNTER	
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$100	D9996	TELEDENTISTRY - ASYNCHRONOUS;	\$0
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$40		INFORMATION STORED AND FORWARDED TO	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS	\$60		DENTIST FOR SUBSEQUENT REVIEW	
	COMPLICATED	, , ,	D9999	BROKEN APPOINTMENT	\$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$15	D0000	ADOLESCENT DENTITION	¢1 00E
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D8090	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7961	BUCCAL / LABIAL FRENECTOMY	\$90	D8660	ADULT DENTITION PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
	(FRENULECTOMY)		20000	MONITOR GROWTH AND DEVELOPMENT	Ψ200
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$90	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$90		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$55		OF RETAINERS)	
D7971	EXCISION OF PERICORONAL GINGIVA	\$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	\$100		FOR REASONS OTHER THAN COMPLETION OF	
ADJUNC	TIVE GENERAL SERVICES		D0000-	TREATMENT	#450
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS,TRACING, PHOTOS, AND MODELS)	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		WOBLEO	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	\$25			
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	\$150			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	\$75			
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	\$30			
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	\$140			
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE	\$70			
D9248	INCREMENT NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	\$50			
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$25			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$15			

¹Additional Prophy within 6 months will be based upon the necessity recommended by the provider. ²Copays listed are also applicable in the specialist office. For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service. *If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider. NCA-01C(v3.0) 275-9617 ©2021-2022 United HealthCare Services, Inc. This plan is underwritten by National Pacific Dental, Inc.

UnitedHealthcare/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 Benefit

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		• Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered

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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
10.	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.
11.	Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
-	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 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.
- 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.
- Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Voluntary 110/covered dental services

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	OSTIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0405	DISEASES - SPECIMEN ANALYSIS	40
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$12
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0472	REPORT	¢ο
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC IMAGES	\$0	D0474	PREP/REPORT ACCESS TISSUE, GROSS & MICROSCOPIC SURG	\$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	MARG PREP/REPORT	\$0
	IMAGE		D0001	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	ΨΟ
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
	RADIOGRAPHIC IMAGE			DOCUMENTATION, MODERATE	, ,
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
D00E4	IMAGE	\$0	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$5
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	
D0270	RADIOGRAPHIC IMAGE BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE –	\$5
D0270	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D	IMAGE CAPTURE ONLY	•
D0272	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0 \$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0 \$0	D0706	RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	\$0
D0274		\$0 \$0	D0700	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE- IMAGE CAPTURE ONLY	φυ
DUZII	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	ΨΟ	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$5		IMAGE-IMAGE CAPTURE ONLY	**
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	\$0
	ACQUISITION, MEASUREMENT AND ANALYSIS	, ,		IMAGE CAPTURE ONLY	
D0364	CONE BEAM CT CAPTURE AND	\$30	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
	INTERPRETATION WITH LIMITED FIELD OF			RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	
	VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$0
D0365	CONE BEAM CT CAPTURE AND	\$30	PREVEN	ITIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D1110 ¹	PROPHYLAXIS - ADULT	\$5
D0000	OF ONE FULL DENTAL ARCH-MANDIBLE	405	D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$35		6 MONTHS	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11201	PROPHYLAXIS - CHILD	\$5
D0367	OF ONE FULL DENTAL ARCH-MAXILLA CONE BEAM CT CAPTURE AND	\$35	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
D0001	INTERPRETATION WITH FIELD OF VIEW OF BOTH	φοσ		MONTHS	
	JAWS		D1206	TOPICALFLUORIDE VARNISH	\$5
D0368	CONE BEAM CT CAPTURE AND	\$35	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
	INTERPRETATION FOR TMJ SERIES INCLUDING		D4040	EXCLUDING VARNISH	40
	TWO OR MORE EXPOSURES		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
	SPECIMEN TO INCLUDE CULTURE AND		D1351	SEALANT - PER TOOTH	\$10
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
D0445	TRANSMISSION OF WRITTEN REPORT	# ^	D4050	CARIES RISK PATIENT- PERM TOOTH	* -
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5

\$10

\$10

D1355

CARIES PREVENTIVE MEDICAMENT

APPLICATION - PER TOOTH

VIRAL CULTURE

D0416

D0417

COLLECTION & PREP OF SALIVA SAMPLE

\$0

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$305
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$35	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$305
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$35	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$305
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$45	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$305
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$45	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$305
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$45	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$305
D1551	RECEM/REBOND BILATERAL SPACE	\$15	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$180
	MAINTAINER – MAXIL		D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$180
D1552	RECEM/REBOND BILATERAL SPACE	\$15	D	INDIRECT	40-0+
D1553	MAINTAINER – MANDIB	\$15	D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	\$250*
D 1000	RECEM/REBOND UNILATERAL SPACE MAINTAINER/QUAD	ΨΙΟ	D2721 D2722*	CROWN - RESIN W/PREDOM BASE METAL CROWN - RESIN WITH NOBLE METAL	\$250* \$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2722 D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$250 \$350*
	MAINTAINER/QUAD		D2740 D2750*	CROWN - PORCELAIN/OLIVAINIC SOBSTRATE CROWN - PORCELAIN FUSED HI NOBLE METAL	\$305*
D1557	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2750	CROWN - PORCELAIN FUSED PREDOM BASE	\$305*
D4550	MAINTAINER-MAXIL	0.45	DZIJI	METAL	φοσο
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$305*
D1575	MAINTAINER-MANDIB DISTAL SHOE SPACE MAINTAINER – FIXED,	\$30	D2753	CROWN PORCELAIN FUSED TO	\$305
2.0.0	UNILATERAL/QUAD	400		TITANIUM/TITANIUM ALLOYS	
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$0	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$305*
	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$305*
RESTOR	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$305*
D2140	AMALGAM - ONE SURFACE	\$15	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$305*
D0450	PRIMARY/PERMANENT	* 00	D2790*	CROWN - FULL CAST HIGH NOBLE METAL	\$305*
D2150	AMALGAM - TWO SURFACES	\$20	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$305*
D2160	PRIMARY/PERMANENT AMALGAM - 3 SURFACES	\$25	D2792*	CROWN - FULL CAST NOBLE METAL	\$305*
	PRIMARY/PERMAMENT	,—·	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$305* \$10
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	\$30	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	·
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$20	D2915	RECEMENT OR RE-BOND INDIRECTLY	\$10
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$25	D2920	FABRICATED PREFABRICATED POST & CORE RECEMENT OR RE-BOND CROWN	\$10
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$30	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$40	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$70	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$60
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$65		PRIMARY	
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$85	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$60
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$105		PERMANENT	.
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$120	D2932	PREFABRICATED RESIN CROWN	\$45
D2510	INLAY - METALLIC - ONE SURFACE	\$200	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$60
D2520	INLAY - METALLIC - TWO SURFACES	\$200	D2934	RESIN WINDOW	\$60
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$200	D250+	PREFABRICATED ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	ΨΟΟ
D2542	ONLAY - METALLIC - TWO SURFACES	\$250	D2940	SEDATIVE FILLING	\$10
D2543	ONLAY - METALLIC THREE SURFACES	\$250	D2941	INTERIM THERAPEUTIC RESTORATION –	\$5
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$250 \$305*		PRIMARY DENTITION	
D2610 D2620	INLAY - PORCELAIN/CERAMIC - 1 SURFACE INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$305* \$305*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$70
D2630		\$305*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$15
D2000	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	φουσ	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$50
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$305*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$50
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$305*	D2954	TOOTH	\$30
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$305*	D239 4	PREFABRICATED POST & CORE ADDITION CROWN	φ30

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962	LABIAL VENEER (PORCELAIN LAMINATE) -	\$600*	D2040	MOLAR	¢οσ
	INDIRECT	,	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$25
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$50	D3911	INTRAORIFICE BARRIER	\$65
	XST PART DENTURE		D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST CONTIC SERVICES	\$15
D2980	CROWN REPAIR	\$35			A 450
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$150
	SURFACE LESIONS		D4211	TEETH QUAD	\$95
	ONTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	ψ95
D3110	PULP CAP - DIRECT	\$5	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$5		PROC/TOOTH	***
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$25	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$160
D0004	JUNC	٨٥٦	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$115
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$55	D4245	APICALLY POSITIONED FLAP	\$175
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$175
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$385
D3240		\$40 \$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$300
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	Ψ40	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$235
D3310	ANTERIOR	\$125		NATURAL TOOTH - FIRST SITE IN QUADRANT	
D3320	BICUSPID	\$215	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3330	MOLAR	\$365		NATURAL TOOTH - EACH ADDITIONAL SITE IN	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$115	D 10=0	QUADRANT	***
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$115	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$255
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$115	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$100
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$155		TOOTH (WHEN NOT PERFORMED IN	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$245		CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$415	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70		TOOTH	
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70		ТООТН	
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	\$75
D3356		\$65		PROSTHETIC CROWNS	
D3330	PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT	ΨΟΟ	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4244	PROSTHETIC CROWNS	¢==+
	TREATMENT		D4341	PERIODONTAL SCAL & ROOT PLAN	\$55t
D3410	APICOECTOMY SURG - ANT	\$115	D4342	4/>TEETH-QUAD PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$55t
D3421	APICOECTOMY SURG-BICUSPID	\$125	D4346	SCALING IN PRESENCE OF GENERALIZED	\$30
D3425	APICOECTOMY SURG - MOLAR	\$140	Бчочо	MODERATE OR SEVERE GINGIVAL	φου
D3426	APICOECTOMY SURGERY	\$95		INFLAMMATION – FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$60		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$110	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$55t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900		ON A SUBSEQUENT VISIT	
D3471	SURGICAL REPAIR OF ROOT RESORPTION -	\$115	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL	\$65t
	ANTERIOR			AGENTS VIA A CONTROLLED RELEASE VEHICLE	
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$125		INTO DISEASED CREVICULAR TISSUE, PER	
	PREMOLAR		D4910	TOOTH PERIODONTAL MAINTENANCE	\$40
D3473	SURGICAL REPAIR OF ROOT RESORPTION -	\$140	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3E04	MOLAR	ΦΩΕΩ	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250		ABLE PROSTHODONTIC SERVICES	40
	APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$425*
	NEOONI I-MITENION		20110	JOIN EELE DEITIONE IN VICE IN	ΨτΔΟ

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$50*
D5120	COMPLETE DENTURE - MANDIBULAR	\$425*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$440*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$165*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$440*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$400*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$165*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$400*	DE740	MANDIBULAR	¢40 Γ *
D5213	MAX PART DENTUR-CAST METL W/RSN	\$450*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$105*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$450*	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$105*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$145*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$105* \$105*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$105 \$105
	MATERIALS, RESTS AND TEETH)		D5725	RELINE CMPL MAXIL DENTURE (DIRECT)	\$103 \$90*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$155*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$90*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$90*
D5223	MATERIALS, RESTS AND TEETH)	\$145*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$90*
D3223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	Ψ143	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$115*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$115*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$115*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$115*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$155*	D5765	,	\$35
	CAST METAL FRAMEWORK WITH RESIN		D3703	SOFT LINER FOR COMPLETE OR PART REMOVABLE DENTURE-INDIRECT	ΨΟΟ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$160*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$170*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$450*	D5850	TISSUE CONDITIONING MAXILLARY	\$35
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$450*	D5851	TISSUE CONDITIONING MANDIBULAR	\$35
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$145	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$155	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE		D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$330*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$105
D5283	MAXILLARY	\$330*		DENTURE (PER ARCH)	
D3203	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	ψ330	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$450	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD			ENDOSTEAL IMPLANT	
D5286	REMOVABLE UNILATERAL PARTIAL	\$450	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$15	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$15	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	φ213
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$15	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$15		PLACEMENT	·
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$40*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$40*		CROWN	
D5520	MAXILLARY	\$40*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	Ψ40	Deaca	METAL CROWN (HIGH NOBLE METAL)	0040
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$40*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$610
	MANDIBULAR		D6061*	METAL CROWN (PREDOMINATELY BASE METAL) ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$40*	50001	METAL CROWN (NOBLE METAL)	4000
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$40*		(HIGH NOBLE METAL)	
D.F.0.00	MANDIBULAR	4.0 *	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$40*		(PREDOMINATELY BASE METAL)	
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$40*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
20000	TOOTH	Ψτυ	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$40*	D0003	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	υσυ
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$40*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLAN	T SERVICES	-	D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)		D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	\$630	D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	\$275
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	\$245
D6072*	METAL) ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	\$635	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	\$875
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	\$595	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH –	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		MANDIBULAR	
D6075	METAL FPD (NOBLE METAL) IMPLANT SUPPORTED RETAINER FOR CERAMIC	\$615	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH	\$875
D6076*	FPD IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$680	D6113	- MAXILLARY IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	
D0000	FPD - HIGH NOBLE ALLOYS	040	D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND	\$40	D6121	TO TITANIUM/TITANIUM ALLOYS IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS	\$630
	ABUTMENTS		D6122	IMPLANT SUPPT RETAINER FOR METAL	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE	\$180t	D6123	FPD-NOBLE ALLOYS IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	FPD-TITANIUM/TITANIUM ALLOYS RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D6082	AND CLOSURE IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	REPORT SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
	PREDOM. BASE ALLOYS	****	D6191	SEMI-PRECISION ATTACHMENT - PLACEMENT	\$220
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS	\$660	D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	FUSED TO TITANIUM/TITANIUM ALLOYS PROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$305*
	ALLOYS		D6211	PONTIC - CAST PREDOM BASE METAL	\$305* \$305*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	\$165	D6212* D6214*	PONTIC - CAST NOBLE METAL PONTIC - TITANIUM AND TITANIUM ALLOYS	\$305* \$305*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$305*
	SEMI-PRECISION/PRECISION ATTCHMT OF IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	\$305*
DCCCC	ATTCHMT	400	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$305*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	\$60	D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$305*
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	\$70	D6245	PONTIC - PORCELAIN/CERAMIC	\$350*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$250* \$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$250*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED PI	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$305*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$305*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	D0700*	BASE METAL	***
D0540	PROSTHESIS	****	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$305*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$305* \$305*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$325*		RETAINER CROWN - FULL CAST HIGH NOBLE METAL	\$305*
D6601	SURFACES	\$325*	D6791	RETAINER CROWN - FULL CAST	\$305*
D0001	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	φ323	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$305*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2	\$200*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$305*
D.0000±	SURFACES	***		ALLOYS	
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	\$200*	D6920	CONNECTOR BAR	\$85
D6604	RETAINER INLAY - CAST PREDOM BASE METAL	\$200*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	\$10
D6605	2 SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$200*	D6940	STRESS BREAKER	\$150
D0003	3/>SURFACES	Ψ200	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$60
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$200*		JRGERY SERVICES	¢10
D.000=±	SURFACES	***	D7111 D7140	XTRCT CORONAL REMNANTS PRIMARY TOOTH EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$10 \$15
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$200*	D7140	EXTRACTION, ERUPTED TOOTH REQUIRING	\$13 \$50
D6608	SURFACES RETAINER ONLAY - PORCELAIN/CERAMIC 2	\$335*	21210	REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	400
D6609	SURFACES RETAINER ONLAY - PORCELAIN/CERAMIC	\$335*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$65
D6610*	3/MORE SURFACES	\$200*	D7230	REMOVAL IMPACT TOOTH - SOFT TISSUE	\$65 \$95
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	\$200"	D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	ψ35 \$135
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/>	\$200*	2.2.0	BONY	Ų.00
D6612	SURFACES RETAINER ONLAY - CAST PREDOM BASE METAL	\$200*	D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	\$155
	2 SURFACES	****	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS	\$40
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$200*	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$200*		REMOVAL	****
	SURFACES		D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	\$200*	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$80
D6624*	RETAINER INLAY - TITANIUM	\$305*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$120
D6634*	RETAINER ONLAY - TITANIUM	\$305*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$120
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*		TOOTH TO AID ERUPTION	
D0700*	COMPOSITE	*050*	D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	\$250*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$60
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$250*	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	\$20
	BASE METAL		D7288	BRUSH BIOPSY	\$20
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$350*	D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	\$60
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	\$305*	D7311 D7320	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$45 \$80
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$305*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$60
Dezeo*	PREDOMINANTLY BASE METAL	ቀኃ∩⊏*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	\$305*		(SECONDARY EPITHELIALIZATION)	
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$305*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	URGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$120
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$120
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	# 400
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$120
D7460	1.25 CM REMOVAL OF BENIGN NONODONTOGENIC CYST	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$35
B1 100	OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$100
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
D7474	1.25 CM	6400	D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LODGE BALATINGS	\$100 \$100	DOOOL	APPLICATION, PER ARCH	40
D7472 D7473	REMOVAL OF TORUS PALATINUS REMOVAL OF TORUS MANDIBULARIS	\$100 \$100	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REDUCTION OF OSSEOUS TUBEROSITY	\$100 \$100	D9996	ENCOUNTER TELEDENTISTRY - ASYNCHRONOUS:	\$0
D7403	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$40	20000	INFORMATION STORED AND FORWARDED TO	Ψ*
D7510		\$60		DENTIST FOR SUBSEQUENT REVIEW	
DISTI	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	ΨΟΟ	D9999	BROKEN APPOINTMENT	\$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$15	D8090	ADOLESCENT DENTITION	\$1,895
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D0030	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	ψ1,030
D7961	BUCCAL / LABIAL FRENECTOMY	\$90	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
D7000	(FRENULECTOMY)	\$00		MONITOR GROWTH AND DEVELOPMENT	
D7962 D7963	LINGUAL FRENECTOMY (FRENULECTOMY)	\$90	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7903 D7970	FRENULOPLASTY EXC HYPERPLASTIC TISSUE-PER ARCH	\$90 \$55		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7971	EXCISION OF PERICORONAL GINGIVA	\$33 \$40	D8695	OF RETAINERS)	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	\$100	D0093	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF	φ130
	CTIVE GENERAL SERVICES	φίσσ		TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$25			
D9222	ANESTHESIA DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
50222	15 MINUTES	Ų.00			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	\$75			
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	\$30			
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	\$140			
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	\$70			
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	\$50			
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$25			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$15			

¹Additional Prophy within 6 months will be based upon the necessity recommended by the provider.
²Copays listed are also applicable in the specialist office.
For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.
*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

UnitedHealthcare/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 Benefit

_	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

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

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

- 8. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- 9. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 10. 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.Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Contributory 110C/covered dental services

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0		DISEASES - SPECIMEN ANALYSIS	
20.00	REPORT	**	D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$12
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5		REPORT	
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	40
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	\$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	MARG PREP/REPORT	\$0
	IMAGE		D0601	CARIES RISK ASSESSMENT AND	\$0
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	DOCUMENTATION, LOW	\$0
	RADIOGRAPHIC IMAGE		D0002	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	ΨΟ
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0	20000	DOCUMENTATION, HIGH	Ψ
	IMAGE		D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$5
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	, ,
	RADIOGRAPHIC IMAGE		D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE –	\$5
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0		IMAGE CAPTURE ONLY	
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0		RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0		IMAGE CAPTURE ONLY	
	IMAGES		D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$5		IMAGE-IMAGE CAPTURE ONLY	
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	\$0
	ACQUISITION, MEASUREMENT AND ANALYSIS		D0700	IMAGE CAPTURE ONLY	# 0
D0364	CONE BEAM CT CAPTURE AND	\$30	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
	INTERPRETATION WITH LIMITED FIELD OF		D0999	RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY OFFICE VISIT FEE - PER VISIT	\$5
D0365	VIEW-LESS THAN ONE WHOLE JAW	\$30		TIVE SERVICES	Ψ
D0303	CONE BEAM CT CAPTURE AND	φ30			0 5
	INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE		D11101	PROPHYLAXIS - ADULT	\$5
D0366	CONE BEAM CT CAPTURE AND	\$35	D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
20000	INTERPRETATION WITH LIMITED FIELD OF VIEW	400	D11201	6 MONTHS	¢ε
	OF ONE FULL DENTAL ARCH-MAXILLA		D11201	PROPHYLAXIS - CHILD	\$5 *25
D0367	CONE BEAM CT CAPTURE AND	\$35	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	MONTHS TOPICALFLUORIDE VARNISH	\$5
	JAWS				
D0368	CONE BEAM CT CAPTURE AND	\$35	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
	INTERPRETATION FOR TMJ SERIES INCLUDING		D1310	EXCLUDING VARNISH NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
	TWO OR MORE EXPOSURES		D1310	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0 \$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	ORAL HYGIENE INSTRUCTIONS	\$0 \$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0			
	SPECIMEN TO INCLUDE CULTURE AND		D1351	SEALANT - PER TOOTH	\$10
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
D0415	TRANSMISSION OF WRITTEN REPORT COLLECT MICROORGANISMS CULT & SENS	\$0	D1252	CARIES RISK PATIENT- PERM TOOTH	фr
			D1353	SEALANT REPAIR – PER TOOTH	\$5 ¢0
D0416	VIRAL CULTURE	\$10 \$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION – PER TOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$305
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$35	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$305
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$35	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$305
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$45	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$305
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$45	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$305
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$45	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$305
D1551	RECEM/REBOND BILATERAL SPACE	\$15	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$180
	MAINTAINER – MAXIL	.	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$180
D1552	RECEM/REBOND BILATERAL SPACE	\$15	D0700*	INDIRECT	\$050 *
D1553	MAINTAINER – MANDIB RECEM/REBOND UNILATERAL SPACE	\$15	D2720* D2721	CROWN - RESIN WITH HIGH NOBLE METAL	\$250* \$250*
D 1000	MAINTAINER/QUAD	Ψ.0	D2721 D2722*	CROWN - RESIN W/PREDOM BASE METAL CROWN - RESIN WITH NOBLE METAL	\$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2722 D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$250 \$350*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$305*
D1557	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$305*
D4550	MAINTAINER-MAXIL	Ф4 Г	BEIOI	METAL	4000
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$305*
D1575	MAINTAINER-MANDIB DISTAL SHOE SPACE MAINTAINER – FIXED,	\$30	D2753	CROWN PORCELAIN FUSED TO	\$305
	UNILATERAL/QUAD	• • • • • • • • • • • • • • • • • • • •		TITANIUM/TITANIUM ALLOYS	
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$5	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$305*
	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$305*
RESTOR	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$305*
D2140	AMALGAM - ONE SURFACE	\$15	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$305*
D0450	PRIMARY/PERMANENT	000	D2790*	CROWN - FULL CAST HIGH NOBLE METAL	\$305*
D2150	AMALGAM - TWO SURFACES	\$20	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$305*
D2160	PRIMARY/PERMANENT AMALGAM - 3 SURFACES	\$25	D2792*	CROWN - FULL CAST NOBLE METAL	\$305*
D2100	PRIMARY/PERMAMENT	Ψ20	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$305*
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	\$30	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	\$10
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$20	D2915	RECEMENT OR RE-BOND INDIRECTLY	\$10
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$25	D2920	FABRICATED PREFABRICATED POST & CORE RECEMENT OR RE-BOND CROWN	\$10
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$30	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$40	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$70	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$60
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$65	52000	PRIMARY	Ψοσ
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$85	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$60
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$105		PERMANENT	
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$120	D2932	PREFABRICATED RESIN CROWN	\$45
D2510	INLAY - METALLIC - ONE SURFACE	\$200	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$60
D2520	INLAY - METALLIC - TWO SURFACES	\$200	D0004	RESIN WINDOW	400
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$200	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$250	D2940	STEEL CROWN - PRIMARY SEDATIVE FILLING	\$10
D2543	ONLAY - METALLIC THREE SURFACES	\$250	D2941		\$5
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$250	22071	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	Ψ3
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$305*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$70
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$305*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$15
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$305*	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$50
D3640	SURFACES ONLAY DODGELAIN/CEDAMIC 2 SUBFACES		D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$50
D2642 D2643	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$305* \$305*		ТООТН	
D2644	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$305*	D2954	PREFABRICATED POST & CORE ADDITION CROWN	\$30

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
				MOLAR	
D2962	LABIAL VENEER (PORCELAIN LAMINATE) -	\$600*	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$25
D2971	INDIRECT	\$50	D3911	INTRAORIFICE BARRIER	\$65
DZ311	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER XST PART DENTURE	ΨΟΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	OONTIC SERVICES	
D2990		\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$150
D2330	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	ΨΟ		TEETH QUAD	
ENDODO	ONTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$95
D3110	PULP CAP - DIRECT	\$5		TEETH QUAD	
D3120	PULP CAP - INDIRECT	\$5 \$5	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120				PROC/TOOTH	
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$25	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$160
D3221	JUNC	\$55	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$115
DJZZI	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	φυυ	D4245	APICALLY POSITIONED FLAP	\$175
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$175
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$385
D3240		\$40 \$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$300
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$40	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$235
D3310	TOOTH ANTERIOR	\$125		NATURAL TOOTH – FIRST SITE IN QUADRANT	,
D3320	BICUSPID	\$215	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3330				NATURAL TOOTH – EACH ADDITIONAL SITE IN	
	MOLAR	\$365		QUADRANT	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$115	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$255
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$115	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$100
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$115		TOOTH (WHEN NOT PERFORMED IN	
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$155		CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$245		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$415	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70	D 4070	TOOTH	0075
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70	D4322	TOOTH	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	ΨΙΟ
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	PROSTHETIC CROWNS	\$75
	MEDICAMENT REPLACEMENT		D-1020	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	Ψίο
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4341	PERIODONTAL SCAL & ROOT PLAN	\$55t
	TREATMENT			4/>TEETH-QUAD	****
D3410	APICOECTOMY SURG - ANT	\$115	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$55t
D3421	APICOECTOMY SURG-BICUSPID	\$125	D4346	SCALING IN PRESENCE OF GENERALIZED	\$30
D3425	APICOECTOMY SURG - MOLAR	\$140		MODERATE OR SEVERE GINGIVAL	
D3426	APICOECTOMY SURGERY	\$95		INFLAMMATION - FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$60		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$110	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$55t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900		ON A SUBSEQUENT VISIT	
D3471	SURGICAL REPAIR OF ROOT RESORPTION -	\$115	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL	\$65t
	ANTERIOR			AGENTS VIA A CONTROLLED RELEASE VEHICLE	
D3472	SURGICAL REPAIR OF ROOT RESORPTION –	\$125		INTO DISEASED CREVICULAR TISSUE, PER	
	PREMOLAR		D4910	TOOTH PERIODONTAL MAINTENANCE	\$40
D3473	SURGICAL REPAIR OF ROOT RESORPTION -	\$140			
	MOLAR		D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
	APICOECTOMY OR REPAIR ROOT			ABLE PROSTHODONTIC SERVICES	
	RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$425*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$50*
D5120	COMPLETE DENTURE - MANDIBULAR	\$425*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$440*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$165*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$440*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$400*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$165*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$400*	DE740	MANDIBULAR	¢40.Γ*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$450*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$105*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$450*	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$105*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$145*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$105* \$105*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$105 \$105
	MATERIALS, RESTS AND TEETH)		D5723	RELINE CMPL MAXIL DENTURE (DIRECT)	\$103 \$90*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$155*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$90*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$90*
D5223	MATERIALS, RESTS AND TEETH)	\$145*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$90*
D3223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	Ψ143	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$115*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$115*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$115*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$115*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$155*	D5765	,	\$35
	CAST METAL FRAMEWORK WITH RESIN		D0100	SOFT LINER FOR COMPLETE OR PART REMOVABLE DENTURE-INDIRECT	ΨΟΟ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$160*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$170*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$450*	D5850	TISSUE CONDITIONING MAXILLARY	\$35
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$450*	D5851	TISSUE CONDITIONING MANDIBULAR	\$35
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$145	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$155	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE		D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$330*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$105
D5283	MAXILLARY	\$330*		DENTURE (PER ARCH)	
D3203	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	ψ330	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$450	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD			ENDOSTEAL IMPLANT	
D5286	REMOVABLE UNILATERAL PARTIAL	\$450	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$15	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$15	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	φ213
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$15	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$15		PLACEMENT	·
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$40*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$40*		CROWN	
D5520	MAXILLARY	\$40*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	Ψ40	Deaca	METAL CROWN (HIGH NOBLE METAL)	0040
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$40*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$610
	MANDIBULAR		D6061*	METAL CROWN (PREDOMINATELY BASE METAL) ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$40*	50001	METAL CROWN (NOBLE METAL)	4000
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$40*		(HIGH NOBLE METAL)	
D.F.0.00	MANDIBULAR	4.0 *	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$40*		(PREDOMINATELY BASE METAL)	
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$40*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
20000	TOOTH	Ψτυ	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$40*	D0003	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	υσυ
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$40*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	, , , ,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)		20.02	DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	Ψ=. σ
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D6070*	METAL)		D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH –	
D6073	METAL FPD (HIGH NOBLE METAL) ABUTMENT SUPPORTED RETAINER FOR CAST	\$595	D6111	MAXILLARY	\$875
20010	METAL FPD (PREDOMINATELY BASE METAL)	ψ000	DOTTI	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH –	φοισ
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		MANDIBULAR	
	METAL FPD (NOBLE METAL)		D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630	D0400	– MANDIBULAR	# 000
D6080	FPD - HIGH NOBLE ALLOYS	\$40	D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D0000	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED.	Ψ40	D6121	TO TITANIUM/TITANIUM ALLOYS IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND		BOILI	FPD-PREDOM. BASE ALLOYS	4000
	ABUTMENTS		D6122	IMPLANT SUPPT RETAINER FOR METAL	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t		FPD-NOBLE ALLOYS	
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE		D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE		D0400	FPD-TITANIUM/TITANIUM ALLOYS	A.1.5
	IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	REPORT SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
	PREDOM. BASE ALLOYS	,	D6191	SEMI-PRECISION ATTACHMENT - PLACEMENT	\$220
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6194		\$545
	NOBLE ALLOYS		D0104	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	φυτυ
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
DCCCC	TITANIUM/TITANIUM ALLOYS	0.70		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$305*
D0000	ALLOYS	ΨΟΙΟ	D6211	PONTIC - CAST PREDOM BASE METAL	\$305*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$305*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$305*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$305*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$305*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
D6092	ATTCHMT	\$60	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$305*
D0092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	φου	D6243	PONTIC-PORCELAIN FUSED TO	\$305*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	DC045	TITANIUM/TITANIUM ALLOYS	# 0F0*
	SUPPORTED FIXED PARTIAL DENTURE	4.5	D6245	PONTIC - PORCELAIN/CERAMIC	\$350* \$250*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250* \$250*
	AND TITANIUM ALLOYS		D6251 D6252*	PONTIC RESIN W/PREDOM BASE METAL	\$250* \$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D0252°	PONTIC RESIN W/NOBLE METAL	\$250*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED PI	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$305*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$305*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	D0700*	BASE METAL	***
D0540	PROSTHESIS	****	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$305*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$305* \$305*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED	\$85		RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	
D6600	PROSTHESIS RETAINER INLAY - PORCELAIN/CERAMIC 2	\$325*	D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	\$305*
D0004	SURFACES	#205 *	D6791	RETAINER CROWN - FULL CAST	\$305*
D6601	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$325*	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$305*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2	\$200*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$305*
	SURFACES			ALLOYS	
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$200*	D6920	CONNECTOR BAR	\$85
D6604	SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$200*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	\$10
	2 SURFACES		D6940	STRESS BREAKER	\$150
D6605	RETAINER INLAY - CAST PREDOM BASE METAL	\$200*	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$60
D6606*	3/>SURFACES RETAINER INLAY - CAST NOBLE METAL 2	\$200*	ORAL SI	JRGERY SERVICES	
20000	SURFACES	\$200	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$10
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$200*	D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$15
	SURFACES		D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$50
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$335*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$335*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$65
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2	\$200*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$95
D0044#	SURFACES	4000 *	D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$135
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$200*	D7241	BONY REMOVAL IMPACTED TOOTH - COMPLETELY	\$155
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	\$200*	D7250	BONY W/SURG COMP REMOVAL OF RESIDUAL TOOTH ROOTS	\$40
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL	\$200*		(CUTTING PROCEDURE)	
D0044*	3/>SURFACES	****	D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	\$200*	D7261	REMOVAL PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL	\$200*	D7270	TOOTH REIMPLANTATION AND/OR	\$80
	3/MORE SURFACES		2.2.0	STABILIZATION ACCIDENTLY DISPLACED	400
D6624*	RETAINER INLAY - TITANIUM	\$305*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$120
D6634*	RETAINER ONLAY - TITANIUM	\$305*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$120
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D6720*	COMPOSITE RETAINER CROWN - RESIN WITH HIGH NOBLE	\$250*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$130 \$60
20.20	METAL	4200	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$250*	51201	COLLECTION	Ψ20
	BASE METAL		D7288	BRUSH BIOPSY	\$20
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$350*	D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	\$60
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	\$305*	D7311 D7320	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$45 \$80
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$305*	D7320	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$60 \$60
	PREDOMINANTLY BASE METAL		D7321	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
D6752*	RETAINER CROWN - PORCELAIN FUSED TO	\$305*	21070	(SECONDARY EPITHELIALIZATION)	Ψ210
D6753	NOBLE METAL RETAINER CROWN-PORCELAIN FUSED TO	\$305*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
_ 0. 00	TITANIUM/TITANIUM ALLOYS	4000		(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	URGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$120
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$120
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	# 400
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$120
D7460	1.25 CM REMOVAL OF BENIGN NONODONTOGENIC CYST	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$35
27 100	OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$100
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
D7474	1.25 CM	6400	D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LODGE BALATINGS	\$100 \$100	DOOOL	APPLICATION, PER ARCH	40
D7472 D7473	REMOVAL OF TORUS PALATINUS REMOVAL OF TORUS MANDIBULARIS	\$100 \$100	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REDUCTION OF OSSEOUS TUBEROSITY	\$100 \$100	D9996	ENCOUNTER TELEDENTISTRY - ASYNCHRONOUS:	\$0
D7403	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$40	20000	INFORMATION STORED AND FORWARDED TO	Ψ*
D7510		\$60		DENTIST FOR SUBSEQUENT REVIEW	
DISTI	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	ΨΟΟ	D9999	BROKEN APPOINTMENT	\$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$15	D8090	ADOLESCENT DENTITION	\$1,895
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D0030	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	ψ1,030
D7961	BUCCAL / LABIAL FRENECTOMY	\$90	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
D7000	(FRENULECTOMY)	\$00		MONITOR GROWTH AND DEVELOPMENT	
D7962 D7963	LINGUAL FRENECTOMY (FRENULECTOMY)	\$90	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7903 D7970	FRENULOPLASTY EXC HYPERPLASTIC TISSUE-PER ARCH	\$90 \$55		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7971	EXCISION OF PERICORONAL GINGIVA	\$33 \$40	D8695	OF RETAINERS)	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	\$100	D0093	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF	φ130
	CTIVE GENERAL SERVICES	φίσσ		TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$25			
D9222	ANESTHESIA DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
50222	15 MINUTES	Ų.00			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	\$75			
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	\$30			
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	\$140			
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	\$70			
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	\$50			
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$25			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$15			

¹Additional Prophy within 6 months will be based upon the necessity recommended by the provider. ²Copays listed are also applicable in the specialist office. For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service. *If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider. NCA-01C(v3.0) 275-6056 ©2021-2022 United HealthCare Services, Inc. This plan is underwritten by National Pacific Dental, Inc.

UnitedHealthcare/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 Benefit

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		• Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

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

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

- 9. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 10. 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.
- 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Contributory 120/covered dental services

TX D097N

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0105	DISEASES - SPECIMEN ANALYSIS	**
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0470	REPORT	Φ0
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	\$0
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	ФО
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	MARG PREP/REPORT CARIES RISK ASSESSMENT AND	\$0
	IMAGE		D0001	DOCUMENTATION, LOW	Ψ
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
	RADIOGRAPHIC IMAGE			DOCUMENTATION, MODERATE	**
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
D0054	IMAGE	A 0	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	
D0270	RADIOGRAPHIC IMAGE BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0
		•		IMAGE CAPTURE ONLY	
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0		RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0	D0707	IMAGE CAPTURE ONLY	Φ0
D0000	IMAGES	Φ0	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0	D0708	IMAGE-IMAGE CAPTURE ONLY	\$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0706	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	ФО
D0364	ACQUISITION, MEASUREMENT AND ANALYSIS	\$25	D0709	IMAGE CAPTURE ONLY INTRAORAL-COMPLETE SERIES OF	\$0
D0364	CONE BEAM CT CAPTURE AND	φΖΟ	20100	RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	40
	INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$0
D0365	CONE BEAM CT CAPTURE AND	\$25	PREVEN	ITIVE SERVICES	, ,
20000	INTERPRETATION WITH LIMITED FIELD OF VIEW	4=4	D1110¹	PROPHYLAXIS - ADULT	\$0
	OF ONE FULL DENTAL ARCH-MANDIBLE		D1110 ¹		\$25
D0366	CONE BEAM CT CAPTURE AND	\$25	DITIO	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	ΨΣΟ
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11201	PROPHYLAXIS - CHILD	\$0
	OF ONE FULL DENTAL ARCH-MAXILLA		D1120 ¹	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
D0367	CONE BEAM CT CAPTURE AND	\$25	D1120	MONTHS	Ψ20
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	TOPICALFLUORIDE VARNISH	\$0
	JAWS		D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
D0368	CONE BEAM CT CAPTURE AND	\$25		EXCLUDING VARNISH	**
	INTERPRETATION FOR TMJ SERIES INCLUDING		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	TWO OR MORE EXPOSURES INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
		\$5 \$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	ΦU	D1351	SEALANT - PER TOOTH	\$8
	SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND		D1352		\$10
	TRANSMISSION OF WRITTEN REPORT		D 1002	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	ΨΙΟ
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
	e e e	Ţ.J	2.000		ΨΟ

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$250
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$250
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$250
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$40	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$250
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$40	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$250
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$40	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$250
D1551	RECEM/REBOND BILATERAL SPACE	\$15	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$150
	MAINTAINER – MAXIL		D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$150
D1552	RECEM/REBOND BILATERAL SPACE	\$15	D0700*	INDIRECT	ФОГО*
D1553	MAINTAINER – MANDIB RECEM/REBOND UNILATERAL SPACE	\$15	D2720* D2721	CROWN - RESIN WITH HIGH NOBLE METAL CROWN - RESIN W/PREDOM BASE METAL	\$250* \$250*
2.000	MAINTAINER/QUAD	ψ.0	D2721 D2722*	CROWN - RESIN WITH NOBLE METAL	\$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2722 D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$300*
	MAINTAINER/QUAD		D2740 D2750*	CROWN - PORCELAIN/OLIVAINIC SOBSTRATE CROWN - PORCELAIN FUSED HI NOBLE METAL	\$300 \$250*
D1557	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2750 D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$250*
D4550	MAINTAINER-MAXIL	0.45	DZIJI	METAL	Ψ230
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$250*
D1575	MAINTAINER-MANDIB DISTAL SHOE SPACE MAINTAINER – FIXED,	\$25	D2753	CROWN PORCELAIN FUSED TO	\$250
2.0.0	UNILATERAL/QUAD	420		TITANIUM/TITANIUM ALLOYS	
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$0	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$250*
	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$250*
RESTOR	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$250*
D2140	AMALGAM - ONE SURFACE	\$8	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$250*
	PRIMARY/PERMANENT		D2790*	CROWN - FULL CAST HIGH NOBLE METAL	\$250*
D2150	AMALGAM - TWO SURFACES	\$15	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$250*
D2160	PRIMARY/PERMANENT	\$22	D2792*	CROWN - FULL CAST NOBLE METAL	\$250*
D2100	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	ΨΖΖ	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$250*
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	\$28	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	\$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$10	D2915	RECEMENT OR RE-BOND INDIRECTLY	\$0
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$20	D2920	FABRICATED PREFABRICATED POST & CORE RECEMENT OR RE-BOND CROWN	0.9
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$30	D2920 D2921	REATTACHMENT OF TOOTH FRAGMENT	\$0 \$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$38	D2921	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$45	D2929 D2930		\$25
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$50	D2330	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	ΨΖΟ
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$55	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$85		PERMANENT	
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$95	D2932	PREFABRICATED RESIN CROWN	\$40
D2510	INLAY - METALLIC - ONE SURFACE	\$185	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$40
D2520	INLAY - METALLIC - TWO SURFACES	\$185		RESIN WINDOW	
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$185	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$225	D2940	STEEL CROWN - PRIMARY SEDATIVE FILLING	\$0
D2543	ONLAY - METALLIC THREE SURFACES	\$225	D2940 D2941		\$5
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$225	D2341	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	ΨΟ
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$250*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$50
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$10
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$250*	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$50
D0040	SURFACES	*****	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$50
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250* \$250*		TOOTH	
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$250* \$250*	D2954	PREFABRICATED POST & CORE ADDITION	\$30
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$250*		CROWN	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	RATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962		\$600*		MOLAR	
D2302	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	φουσ	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$50	D3911	INTRAORIFICE BARRIER	\$50
B2011	XST PART DENTURE	ΨΟΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	OONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	\$130
ENDOD	SURFACE LESIONS DNTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$85
		Φ.		TEETH QUAD	,
D3110	PULP CAP - DIRECT	\$5	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$5		PROC/TOOTH	
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$5	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$150
D0004	JUNC	***	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$110
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$30	D4245	APICALLY POSITIONED FLAP	\$165
D2000	TEETH PARTIAL BUILDOTOMY	# 00	D4249	CLIN CROWN LEN - HARD TISSUE	\$150
D3222	PARTIAL PULPOTOMY	\$60	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$355
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$275
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$40	D4263		\$205
D2240	TOOTH	Ф40 Г	D4203	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	ΨΣΟΟ
D3310	ANTERIOR	\$125	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3320	BICUSPID	\$175		NATURAL TOOTH – EACH ADDITIONAL SITE IN	***
D3330	MOLAR	\$325		QUADRANT	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$235
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$85	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$90
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$85		TOOTH (WHEN NOT PERFORMED IN	
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$145		CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$195		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$345	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70	D. 40=0	TOOTH	***
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70	D4322	TOOTH	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	Φ/ 3
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	PROSTHETIC CROWNS	\$75
	MEDICAMENT REPLACEMENT		D4020	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	Ψίδ
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4341	PERIODONTAL SCAL & ROOT PLAN	\$55t
	TREATMENT			4/>TEETH-QUAD	,,,,,
D3410	APICOECTOMY SURG - ANT	\$95	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$50t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$30
D3425	APICOECTOMY SURG - MOLAR	\$95		MODERATE OR SEVERE GINGIVAL	
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION - FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$55t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900		ON A SUBSEQUENT VISIT	
D3471	SURGICAL REPAIR OF ROOT RESORPTION -	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE	\$65t
D3472	ANTERIOR SURGICAL REPAIR OF ROOT RESORPTION –	\$95		INTO DISEASED CREVICULAR TISSUE, PER TOOTH	
B	PREMOLAR		D4910	PERIODONTAL MAINTENANCE	\$40
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	\$95	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3501	MULAR SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
_ 500 1	APICOECTOMY OR REPAIR ROOT	Ψ200	REMOV	ABLE PROSTHODONTIC SERVICES	
	RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$350*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$40*
D5120	COMPLETE DENTURE - MANDIBULAR	\$350*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$400*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$400*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$325*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$325*	DE740	MANDIBULAR	↑7 Г*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$425*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$75*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$425*	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$75*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$145*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$75* \$75*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$75 \$75
	MATERIALS, RESTS AND TEETH)		D5725	RELINE CMPL MAXIL DENTURE (DIRECT)	\$75 \$55*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$155*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$55*
D5223	MATERIALS, RESTS AND TEETH)	\$145*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$55*
DOZZO	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ψ140	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$75*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$75*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$75*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$75*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$155*	D5765	SOFT LINER FOR COMPLETE OR PART	\$20
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	ΨΣΟ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$145*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$155*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$425*	D5850	TISSUE CONDITIONING MAXILLARY	\$20
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$425*	D5851	TISSUE CONDITIONING MANDIBULAR	\$20
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$145	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$155	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE	****	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$300*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$75
D5283	MAXILLARY	\$300*		DENTURE (PER ARCH)	
D0200	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	Ψ300	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$425	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	****
D5286	REMOVABLE UNILATERAL PARTIAL	\$425	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$10	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$10	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖΙΟ
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$10	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$10		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$35*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$35*		CROWN	
D5520	MAXILLARY PERI ACE MISSING/PROVEN TEETLY COMPLETE	\$35*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	ΨΟΟ	Denen	METAL CROWN (HIGH NOBLE METAL)	¢640
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$35*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$35*		METAL CROWN (NOBLE METAL)	,,,,,
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$35*		(HIGH NOBLE METAL)	
DEGOO	MANDIBULAR	ሰ ጋርታ	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$35*	D0004	(PREDOMINATELY BASE METAL)	4-4-
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$35*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
_ 5550	TOOTH	400	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$35*	50000	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	φοσο
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$40*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)		20.02	DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	ΨΞ. ΰ
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH –	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	,,,,
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40		TO TITANIUM/TITANIUM ALLOYS	
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	φοσο
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	*****	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	,
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$250*
20000	ALLOYS	ψοιο	D6211	PONTIC - CAST PREDOM BASE METAL	\$250*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$250*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$250*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$250*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$250*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$250*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$250*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$300*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$250*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED PI	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$250*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$250*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	D0700*	BASE METAL	фо го +
DCE 40	PROSTHESIS	#200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$250* \$200*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC RETAINER CROWN - 3/4 TITANIUM/TITANIUM	\$300* \$250*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	ALLOYS RETAINER CROWN - 5/4 THANIOW/THANIOW ALLOYS	\$250*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$270*		METAL	
D6601	SURFACES RETAINER INLAY - PORCELAIN/CERAMIC	\$270*	D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	\$250*
	3/MORE SURFACES		D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	\$250*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	\$185*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	\$250*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$185*	D6920	CONNECTOR BAR	\$85
D6604	SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$185*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	\$0
D6605	2 SURFACES	\$185*	D6940	STRESS BREAKER	\$125
D0003	RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$100	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$60
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$185*		JRGERY SERVICES	\$10
D0007*	SURFACES	0405*	D7111 D7140	XTRCT CORONAL REMNANTS PRIMARY TOOTH EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$10 \$10
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	\$185*	D7140	EXTRACTION, ERUPTED TOOTH REQUIRING	\$30
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$280*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	,,,
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC	\$280*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$65
D6610*	3/MORE SURFACES RETAINER ONLAY - CAST HI NOBLE METAL 2	\$185*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$85
	SURFACES		D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$125
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$175*	D7241	BONY REMOVAL IMPACTED TOOTH - COMPLETELY	\$150
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	\$175*	D7250	BONY W/SURG COMP REMOVAL OF RESIDUAL TOOTH ROOTS	\$40
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$175*	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$175*	57201	REMOVAL	ψ100
	SURFACES		D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	\$175*	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$50
D6624*	RETAINER INLAY - TITANIUM	\$250*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634* D6710	RETAINER ONLAY - TITANIUM	\$250* \$185*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$90
D07 10	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	\$105	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE	\$250*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$60
D6721	METAL RETAINER CROWN - RESIN PREDOMINANTLY	\$250*	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	\$20
	BASE METAL		D7288	BRUSH BIOPSY	\$20
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$300*	D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	\$40
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	\$250*	D7311 D7320	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$15 \$60
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7320	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$25
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
D0702	NOBLE METAL	ΨΣΟΟ		(SECONDARY EPITHELIALIZATION)	
D6753	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$250*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	\$670

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$100
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$100
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	# 400
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$100
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$35
D1400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$90
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
	1.25 CM	**-	D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$85		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$65	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$65	D9996	ENCOUNTER TELEPENTISTRY ASYMCURONOUS	\$0
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$65	D3330	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	ΨΟ
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$35		DENTIST FOR SUBSEQUENT REVIEW	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	\$35	D9999	BROKEN APPOINTMENT	\$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$10	D0000	ADOLESCENT DENTITION	¢1 00E
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	\$1,895
D7961	BUCCAL / LABIAL FRENECTOMY	\$45	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
	(FRENULECTOMY)			MONITOR GROWTH AND DEVELOPMENT	,
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$45	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$45		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$55	D0005	OF RETAINERS)	0.150
D7971	EXCISION OF PERICORONAL GINGIVA	\$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY ETIVE GENERAL SERVICES	\$100		FOR REASONS OTHER THAN COMPLETION OF TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
	ANESTHESIA				
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
D0000	15 MINUTES	^- -			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
D9230	15 MINUTE INCREMENT ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
D3230	NITROUS OXIDE	ΨΟΟ			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
	SEDATION/ANESTHESIA - FIRST 15 MINUTES				
D9243	INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
	SEDATION/ANALGESIA - EACH 15 MINUTE				
D9248	INCREMENT	\$50			
D3240	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND	ΨΟΟ			
	MODERATE SEDATION				
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$10			

'Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

2 Copays listed are also applicable in the specialist office.

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

1 If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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This plan is underwritten by National Pacific Dental, Inc.

UnitedHealthcare/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 Benefit

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		• Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

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

Delle	ent on this Flan'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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

- Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 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.
- 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Voluntary 120C/covered dental services

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	50405	DISEASES - SPECIMEN ANALYSIS	**
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0470	REPORT	Φ0
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	\$0
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	ΦΟ
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	CARIES RISK ASSESSMENT AND	\$0
	IMAGE		20001	DOCUMENTATION, LOW	Ψ0
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
	RADIOGRAPHIC IMAGE			DOCUMENTATION, MODERATE	, ,
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
D0054	IMAGE	40	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	
D0270	RADIOGRAPHIC IMAGE BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0
				IMAGE CAPTURE ONLY	
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0		RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0	D0707	IMAGE CAPTURE ONLY	Φ0
D0220	IMAGES	(0	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0	D0708	IMAGE-IMAGE CAPTURE ONLY	\$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0700	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE- IMAGE CAPTURE ONLY	ΦΟ
D0364	ACQUISITION, MEASUREMENT AND ANALYSIS	\$25	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
D0304	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF	ΨΖϽ		RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	**
	VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$5
D0365	CONE BEAM CT CAPTURE AND	\$25	PREVEN	ITIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11101	PROPHYLAXIS - ADULT	\$0
	OF ONE FULL DENTAL ARCH-MANDIBLE		D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$25	BIIIO	6 MONTHS	Ψ20
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11201	PROPHYLAXIS - CHILD	\$0
	OF ONE FULL DENTAL ARCH-MAXILLA		D11201	- PROPHYLAXIS - CHILD 1 ADD, PROPHY WITHIN 6	\$25
D0367	CONE BEAM CT CAPTURE AND	\$25		MONTHS	 -
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	TOPICALFLUORIDE VARNISH	\$0
D0000	JAWS	A05	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
D0368	CONE BEAM CT CAPTURE AND	\$25		EXCLUDING VARNISH	
	INTERPRETATION FOR TMJ SERIES INCLUDING		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	TWO OR MORE EXPOSURES INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D0414		\$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
DV4 14	LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND	Ψ	D1351	SEALANT - PER TOOTH	\$8
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
	TRANSMISSION OF WRITTEN REPORT			CARIES RISK PATIENT- PERM TOOTH	Ψ.0
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION – PER TOOTH	+•
20711	COLLEGION WITHER OF OALIVA OAIVII LE	ΨΙΟ		A LIGATION - LECTOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$250
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$250
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$250
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$40	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$250
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$40	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$250
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$40	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$250
D1551	RECEM/REBOND BILATERAL SPACE	\$15	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$150
	MAINTAINER – MAXIL	.	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$150
D1552	RECEM/REBOND BILATERAL SPACE	\$15	D0700*	INDIRECT	ФО Г О*
D1553	MAINTAINER – MANDIB RECEM/REBOND UNILATERAL SPACE	\$15	D2720* D2721	CROWN - RESIN WITH HIGH NOBLE METAL CROWN - RESIN W/PREDOM BASE METAL	\$250* \$250*
	MAINTAINER/QUAD	***	D2721*	CROWN - RESIN WITH NOBLE METAL	\$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2722	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$300*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$250*
D1557	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$250*
D1EE0	MAINTAINER-MAXIL	\$15	22.0.	METAL METAL	¥ 200
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	614	D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$250*
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED.	\$25	D2753	CROWN PORCELAIN FUSED TO	\$250
	UNILATERAL/QUAD			TITANIUM/TITANIUM ALLOYS	
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$5	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$250*
	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$250*
	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$250*
D2140	AMALGAM - ONE SURFACE	\$8	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$250*
D2150	PRIMARY/PERMANENT	\$15	D2790*	CROWN - FULL CAST PREDOM BASE METAL	\$250*
DZ 130	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	φισ	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$250*
D2160	AMALGAM - 3 SURFACES	\$22	D2792* D2794*	CROWN - FULL CAST NOBLE METAL CROWN - TITANIUM AND TITANIUM ALLOYS	\$250* \$250*
	PRIMARY/PERMAMENT		D2734 D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$230 \$0
D2161	AMALGAM - FOUR/MORE SURFACES	\$28		OR PART COV REST	**
D2330	PRIMARY/PERMANENT RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$10	D2915	RECEMENT OR RE-BOND INDIRECTLY	\$0
D2331	RESIN COMPOSITE - ONE SONI ACE ANTERIOR RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$20		FABRICATED PREFABRICATED POST & CORE	
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$30	D2920	RECEMENT OR RE-BOND CROWN	\$0
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$38	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2330	RESIN COMPOSITE CROWN ANTERIOR	\$36 \$45	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$50	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$55	D2931	PRIMARY	\$25
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$85	D2331	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	ΨΖΟ
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$95	D2932	PREFABRICATED RESIN CROWN	\$40
D2510	INLAY - METALLIC - ONE SURFACE	\$185	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$40
D2520	INLAY - METALLIC - TWO SURFACES	\$185		RESIN WINDOW	
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$185	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$225	20010	STEEL CROWN - PRIMARY	••
D2543	ONLAY - METALLIC THREE SURFACES	\$225	D2940	SEDATIVE FILLING	\$0
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$225	D2941	INTERIM THERAPEUTIC RESTORATION –	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$250*	D2950	PRIMARY DENTITION CORE BUILDUP INCLUDING ANY PINS	\$50
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$10
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$250*	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$50
D0045	SURFACES	**=*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$50
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*		TOOTH	
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$250* \$250*	D2954	PREFABRICATED POST & CORE ADDITION	\$30
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$250*		CROWN	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	RATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962		\$600*		MOLAR	
D2302	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	φουσ	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$50	D3911	INTRAORIFICE BARRIER	\$50
B2011	XST PART DENTURE	ΨΟΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	OONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	\$130
ENDOD	SURFACE LESIONS DNTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$85
		Φ.		TEETH QUAD	,
D3110	PULP CAP - DIRECT	\$5	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$5		PROC/TOOTH	
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$5	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$150
D0004	JUNC	***	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$110
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$30	D4245	APICALLY POSITIONED FLAP	\$165
D2000	TEETH PARTIAL BUILDOTOMY	# 00	D4249	CLIN CROWN LEN - HARD TISSUE	\$150
D3222	PARTIAL PULPOTOMY	\$60	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$355
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$275
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$40	D4263		\$205
D2240	TOOTH	Ф40 Г	D4203	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	Ψ203
D3310	ANTERIOR	\$125	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3320	BICUSPID	\$175		NATURAL TOOTH – EACH ADDITIONAL SITE IN	***
D3330	MOLAR	\$325		QUADRANT	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$235
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$85	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$90
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$85		TOOTH (WHEN NOT PERFORMED IN	
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$145		CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$195		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$345	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70	D. 40=0	TOOTH	***
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70	D4322	TOOTH	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	Φ/ 3
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	PROSTHETIC CROWNS	\$75
	MEDICAMENT REPLACEMENT		D4020	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	Ψίδ
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4341	PERIODONTAL SCAL & ROOT PLAN	\$55t
	TREATMENT			4/>TEETH-QUAD	,,,,,
D3410	APICOECTOMY SURG - ANT	\$95	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$50t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$30
D3425	APICOECTOMY SURG - MOLAR	\$95		MODERATE OR SEVERE GINGIVAL	
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION - FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$55t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900		ON A SUBSEQUENT VISIT	
D3471	SURGICAL REPAIR OF ROOT RESORPTION -	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE	\$65t
D3472	ANTERIOR SURGICAL REPAIR OF ROOT RESORPTION –	\$95		INTO DISEASED CREVICULAR TISSUE, PER TOOTH	
B	PREMOLAR		D4910	PERIODONTAL MAINTENANCE	\$40
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	\$95	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3501	MULAR SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
_ 500 1	APICOECTOMY OR REPAIR ROOT	Ψ200	REMOV	ABLE PROSTHODONTIC SERVICES	
	RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$350*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$40*
D5120	COMPLETE DENTURE - MANDIBULAR	\$350*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$400*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$400*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$325*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$325*	DE740	MANDIBULAR	↑7 Г*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$425*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$75*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$425*	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$75*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$145*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$75* \$75*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$75 \$75
	MATERIALS, RESTS AND TEETH)		D5725	RELINE CMPL MAXIL DENTURE (DIRECT)	\$75 \$55*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$155*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$55*
D5223	MATERIALS, RESTS AND TEETH)	\$145*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$55*
DOZZO	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ψ140	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$75*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$75*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$75*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$75*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$155*	D5765	SOFT LINER FOR COMPLETE OR PART	\$20
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	ΨΣΟ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$145*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$155*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$425*	D5850	TISSUE CONDITIONING MAXILLARY	\$20
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$425*	D5851	TISSUE CONDITIONING MANDIBULAR	\$20
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$145	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$155	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE	****	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$300*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$75
D5283	MAXILLARY	\$300*		DENTURE (PER ARCH)	
D0200	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	Ψ300	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$425	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	****
D5286	REMOVABLE UNILATERAL PARTIAL	\$425	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$10	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$10	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖΙΟ
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$10	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$10		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$35*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$35*		CROWN	
D5520	MAXILLARY PERI ACE MISSING/PROVEN TEETLY COMPLETE	\$35*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	ΨΟΟ	Denen	METAL CROWN (HIGH NOBLE METAL)	¢640
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$35*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$35*		METAL CROWN (NOBLE METAL)	,,,,,
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$35*		(HIGH NOBLE METAL)	
DEGOO	MANDIBULAR	ሰ ጋርታ	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$35*	D0004	(PREDOMINATELY BASE METAL)	A-A-
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$35*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
_ 5550	TOOTH	400	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$35*	50000	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	φοσο
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$40*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)		20.02	DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	ΨΞ. ΰ
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH –	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	,,,,
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40		TO TITANIUM/TITANIUM ALLOYS	****
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	φοσο
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	*****	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	,
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$250*
20000	ALLOYS	ψοιο	D6211	PONTIC - CAST PREDOM BASE METAL	\$250*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$250*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$250*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$250*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$250*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$250*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$250*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$300*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$250*

FIXED PF D6253	ROSTHODONTIC SERVICES INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION RETAINER - CASE METAL FOR RESIN FIXED	\$160	D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$250*
	OF DIAG PRIOR TO FINAL IMPRESSION	\$160			
D6E4E			D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$250*
D0343		\$250	DC700*	BASE METAL	#050*
D6548	PROSTHESIS	\$300*	D6782* D6783	RETAINER CROWN - 3/4 CAST NOBLE METAL RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$250* \$300*
D0040	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300	D6784	RETAINER CROWN - 3/4 FORGELAIN/GERAINIG	\$250*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	ALLOYS RETAINER CROWN - FULL CAST HIGH NOBLE	\$250*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$270*		METAL	,
D6601	SURFACES RETAINER INLAY - PORCELAIN/CERAMIC	\$270*	D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	\$250*
D6602*	3/MORE SURFACES	\$185*	D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	\$250*
D0002	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	Ψ100	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	\$250*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$185*	D6920	CONNECTOR BAR	\$85
D6604	SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$185*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	\$0
	2 SURFACES		D6940	STRESS BREAKER	\$125
D6605	RETAINER INLAY - CAST PREDOM BASE METAL	\$185*	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$60
D6606*	3/>SURFACES RETAINER INLAY - CAST NOBLE METAL 2	\$185*	ORAL SI	JRGERY SERVICES	
20000	SURFACES	\$100	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$10
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$185*	D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$10
D0000	SURFACES	#000 *	D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$30
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$280*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$280*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$65
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2	\$185*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$85
	SURFACES		D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$125
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$175*	D7241	BONY REMOVAL IMPACTED TOOTH - COMPLETELY	\$150
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL	\$175*		BONY W/SURG COMP	•
D6613	2 SURFACES RETAINER ONLAY - CAST PREDOM BASE METAL	\$175*	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	\$40
	3/>SURFACES	****	D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$175*	D7004	REMOVAL	*
D6615*	SURFACES	\$175*	D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D0013	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	Ψ175	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$50
D6624*	RETAINER INLAY - TITANIUM	\$250*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634*	RETAINER ONLAY - TITANIUM	\$250*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$90
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D6720*	COMPOSITE RETAINER CROWN - RESIN WITH HIGH NOBLE	\$250*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$60
	METAL		D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$250*		COLLECTION	
D6722*	BASE METAL RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$300*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7310 D7311	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$40 \$15
	HIGH NOBLE METAL		D7311	ALVEOLOPLASTY ROUND XTRCT 1-3 TLETTI	\$13 \$60
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$25
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
	NOBLE METAL	,	D7050	(SECONDARY EPITHELIALIZATION)	***
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$250*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$100
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$100
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	# 400
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$100
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$35
D1400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$90
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
	1.25 CM	**-	D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$85		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$65	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$65	D9996	ENCOUNTER TELEPENTISTRY ASYMCURONOUS	\$0
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$65	D3330	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	ΨΟ
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$35		DENTIST FOR SUBSEQUENT REVIEW	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	\$35	D9999	BROKEN APPOINTMENT	\$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$10	D0000	ADOLESCENT DENTITION	¢1 00E
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	\$1,895
D7961	BUCCAL / LABIAL FRENECTOMY	\$45	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
	(FRENULECTOMY)			MONITOR GROWTH AND DEVELOPMENT	,
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$45	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$45		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$55	D0005	OF RETAINERS)	0.150
D7971	EXCISION OF PERICORONAL GINGIVA	\$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY ETIVE GENERAL SERVICES	\$100		FOR REASONS OTHER THAN COMPLETION OF TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
	ANESTHESIA				
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
D0000	15 MINUTES	^- -			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
D9230	15 MINUTE INCREMENT ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
D3230	NITROUS OXIDE	ΨΟΟ			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
	SEDATION/ANESTHESIA - FIRST 15 MINUTES				
D9243	INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
	SEDATION/ANALGESIA - EACH 15 MINUTE				
D9248	INCREMENT	\$50			
D3240	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND	ΨΟΟ			
	MODERATE SEDATION				
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$10			

¹Additional Prophy within 6 months will be based upon the necessity recommended by the provider.
²Copays listed are also applicable in the specialist office.
For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.
*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

UnitedHealthcare/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 Benefit

_	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

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

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
10.	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.

- 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Voluntary 120/covered dental services

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0425	DISEASES - SPECIMEN ANALYSIS CARIES SUSCEPTIBILITY TESTS	\$0
	REPORT		D0425 D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$0 \$20
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	PULP VITALITY TESTS	\$20 \$0
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0400	DIAGNOSTIC CASTS	\$0 \$0
D0180	VISIT COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0100	SCREENING OF A PATIENT	\$5		REPORT	•
D0190	ASSESMENT OF A PATIENT	\$5 \$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0		PREP/REPORT	
D0210	IMAGES	ΨΟ	D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	\$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0004	MARG PREP/REPORT	00
	IMAGE		D0601	CARIES RISK ASSESSMENT AND	\$0
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	DOCUMENTATION, LOW CARIES RISK ASSESSMENT AND	\$0
	RADIOGRAPHIC IMAGE		D0002	DOCUMENTATION, MODERATE	Ψ
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
D0251	IMAGE	\$0	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	Φ0		CAPTURE ONLY	
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	IMAGE CAPTURE ONLY	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	\$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0		IMAGE CAPTURE ONLY	**
	IMAGES		D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0		IMAGE-IMAGE CAPTURE ONLY	
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	\$0
	ACQUISITION, MEASUREMENT AND ANALYSIS		D0700	IMAGE CAPTURE ONLY	\$0
D0364	CONE BEAM CT CAPTURE AND	\$25	D0709	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	Φ0
	INTERPRETATION WITH LIMITED FIELD OF		D0999	OFFICE VISIT FEE - PER VISIT	\$0
D0365	VIEW-LESS THAN ONE WHOLE JAW CONE BEAM CT CAPTURE AND	\$25		VITIVE SERVICES	**
	INTERPRETATION WITH LIMITED FIELD OF VIEW	•	D1110 ¹	PROPHYLAXIS - ADULT	\$0
	OF ONE FULL DENTAL ARCH-MANDIBLE		D1110¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$25		6 MONTHS	•
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11201	PROPHYLAXIS - CHILD	\$0
D0267	OF ONE FULL DENTAL ARCH-MAXILLA	¢0E	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH	\$25		MONTHS	
	JAWS		D1206	TOPICALFLUORIDE VARNISH	\$0
D0368	CONE BEAM CT CAPTURE AND	\$25	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
	INTERPRETATION FOR TMJ SERIES INCLUDING		D4240	EXCLUDING VARNISH	Φ0
	TWO OR MORE EXPOSURES		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0 \$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320 D1330	TOBACCO CNSL CNTRL&PREVION ORL DZ ORAL HYGIENE INSTRUCTIONS	\$0 \$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0			•
	SPECIMEN TO INCLUDE CULTURE AND		D1351 D1352	SEALANT - PER TOOTH	\$8 \$10
	SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT		אניטו ע	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	φιυ
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION – PER TOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$250
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$250
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$250
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$40	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$250
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$40	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$250
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$40	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$250
D1551	RECEM/REBOND BILATERAL SPACE	\$15	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$150
	MAINTAINER – MAXIL	.	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$150
D1552	RECEM/REBOND BILATERAL SPACE	\$15	D0700*	INDIRECT	ФО Г О*
D1553	MAINTAINER – MANDIB RECEM/REBOND UNILATERAL SPACE	\$15	D2720* D2721	CROWN - RESIN WITH HIGH NOBLE METAL CROWN - RESIN W/PREDOM BASE METAL	\$250* \$250*
	MAINTAINER/QUAD	***	D2721 D2722*	CROWN - RESIN WITH NOBLE METAL	\$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$300*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$250*
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$15	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$250*
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2752*	METAL CROWN - PORCELAIN FUSED NOBLE METAL	\$250*
D1575	MAINTAINER-MANDIB	\$25	D2753	CROWN PORCELAIN FUSED TO	\$250
פוטוט	DISTAL SHOE SPACE MAINTAINER – FIXED, UNILATERAL/QUAD	φΖΟ		TITANIUM/TITANIUM ALLOYS	,
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$0	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$250*
	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$250*
RESTOR	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$250*
D2140	AMALGAM - ONE SURFACE	\$8	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$250*
	PRIMARY/PERMANENT		D2790*	CROWN - FULL CAST HIGH NOBLE METAL	\$250*
D2150	AMALGAM - TWO SURFACES	\$15	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$250*
D2160	PRIMARY/PERMANENT	\$22	D2792*	CROWN - FULL CAST NOBLE METAL	\$250*
D2100	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	ΨΖΖ	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$250*
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	\$28	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	\$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$10	D2915	RECEMENT OR RE-BOND INDIRECTLY	\$0
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$20	D2920	FABRICATED PREFABRICATED POST & CORE RECEMENT OR RE-BOND CROWN	\$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$30	D2920 D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$38	D2921	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$45	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$50	<i>D</i> 2000	PRIMARY	ΨΞΟ
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$55	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$85		PERMANENT	
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$95	D2932	PREFABRICATED RESIN CROWN	\$40
D2510	INLAY - METALLIC - ONE SURFACE	\$185	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$40
D2520	INLAY - METALLIC - TWO SURFACES	\$185	D0024	RESIN WINDOW	# CO
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$185	D2934	PREFABRICATED ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$225	D2940	SEDATIVE FILLING	\$0
D2543	ONLAY - METALLIC THREE SURFACES	\$225	D2941	INTERIM THERAPEUTIC RESTORATION –	\$5
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$225		PRIMARY DENTITION	,
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$250*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$50
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250* \$250*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$10
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	\$250*	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$50
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$50
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$250*	D2054	TOOTH	ሰ ን ኃ
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$250*	D2954	PREFABRICATED POST & CORE ADDITION CROWN	\$30

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962	LABIAL VENEER (PORCELAIN LAMINATE) -	\$600*	D2040	MOLAR	Ф4 Г
	INDIRECT	,	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15 \$50
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$50	D3911	INTRAORIFICE BARRIER	\$50
	XST PART DENTURE		D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST CONTIC SERVICES	\$15
D2980	CROWN REPAIR	\$35			\$100
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$130
	SURFACE LESIONS		D4211	TEETH QUAD	\$85
	ONTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	ψΟΟ
D3110	PULP CAP - DIRECT	\$5	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$5		PROC/TOOTH	***
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$5	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$150
D0004	JUNC	400	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$110
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$30	D4245	APICALLY POSITIONED FLAP	\$165
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$150
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$355
D3240		\$40 \$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$275
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	Ψ40	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$205
D3310	ANTERIOR	\$125		NATURAL TOOTH - FIRST SITE IN QUADRANT	
D3320	BICUSPID	\$175	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3330	MOLAR	\$325		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D 10=0	QUADRANT	***
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$85	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$235
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$85	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$90
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$145		TOOTH (WHEN NOT PERFORMED IN	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$195		CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$345	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70		TOOTH	
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70		ТООТН	
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	\$75
D3356		\$65		PROSTHETIC CROWNS	
D3330	PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT	ΨΟΟ	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4244	PROSTHETIC CROWNS	¢==+
	TREATMENT		D4341	PERIODONTAL SCAL & ROOT PLAN	\$55t
D3410	APICOECTOMY SURG - ANT	\$95	D4342	4/>TEETH-QUAD PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$50t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$30
D3425	APICOECTOMY SURG - MOLAR	\$95	Бчочо	MODERATE OR SEVERE GINGIVAL	φου
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION – FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$55t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900		ON A SUBSEQUENT VISIT	
D3471	SURGICAL REPAIR OF ROOT RESORPTION -	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL	\$65t
	ANTERIOR			AGENTS VIA A CONTROLLED RELEASE VEHICLE	
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$95		INTO DISEASED CREVICULAR TISSUE, PER	
	PREMOLAR		D4910	TOOTH PERIODONTAL MAINTENANCE	\$40
D3473	SURGICAL REPAIR OF ROOT RESORPTION -	\$95	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3E04	MOLAR	ΦΩΕΩ	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250		ABLE PROSTHODONTIC SERVICES	40
	APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$350*
	NEOONI I-MITENION		20110	JOIN EELE DEITIONE IN VICE IN	ΨΟΟΟ

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$40*
D5120	COMPLETE DENTURE - MANDIBULAR	\$350*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$400*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$400*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$325*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$325*	DE740	MANDIBULAR	↑7 Г*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$425*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$75*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$425*	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$75*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$145*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$75* \$75*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$75 \$75
	MATERIALS, RESTS AND TEETH)		D5723	RELINE CMPL MAXIL DENTURE (DIRECT)	\$75 \$55*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$155*	D5730	RELINE CMPL MAND DENTURE (DIRECT) RELINE CMPL MAND DENTURE (DIRECT)	\$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$55*
D5223	MATERIALS, RESTS AND TEETH)	\$145*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$55*
DOZZO	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ψ14 0	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$75*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$75*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$75*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$75*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$155*	D5765	SOFT LINER FOR COMPLETE OR PART	\$20
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	ΨΣΟ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$145*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$155*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$425*	D5850	TISSUE CONDITIONING MAXILLARY	\$20
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$425*	D5851	TISSUE CONDITIONING MANDIBULAR	\$20
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$145	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$155	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
D=000	DENTURE-FLEX BASE	***	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$300*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$75
D5283	MAXILLARY REMOVABLE UNILATERAL PARTIAL DENTURE -	\$300*		DENTURE (PER ARCH)	
D0200	MANDIBULAR	φοσο	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$425	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	****
D5286	REMOVABLE UNILATERAL PARTIAL	\$425	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$10	D6056	BAR PREFARRICATED ADUTMENT, INCLUDES MOD	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$10	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖ13
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$10	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$10		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$35*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$35*		CROWN	
D5520	MAXILLARY REPLACE MISSING/BROKEN TEETH - COMPLETE	\$35*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D0020	DENTURE	ΨΟΟ	D6060	METAL CROWN (HIGH NOBLE METAL)	¢610
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$35*	D0000	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$35*		METAL CROWN (NOBLE METAL)	,,,,,
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$35*		(HIGH NOBLE METAL)	
DEGOO	MANDIBULAR	₾ つ ⊏ *	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	\$35*	D0004*	(PREDOMINATELY BASE METAL)	4505
D5630	REPAIR OR REPLACE BROKEN CLASP - PER	\$35*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
	TOOTH	400	D6065	(NOBLE METAL) IMPLANT SUPPORTED PORCELAIN/CERAMIC	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$35*	20000	CROWN	φοσο
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$40*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)		20.02	DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	ΨΞ. ΰ
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH –	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	,
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40		TO TITANIUM/TITANIUM ALLOYS	****
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	ψΟΟΟ
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	,	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$250*
20000	ALLOYS	ψοιο	D6211	PONTIC - CAST PREDOM BASE METAL	\$250*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$250*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$250*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$250*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$250*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$250*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$250*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$300*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$250*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED P	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$250*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT	\$160		METAL	
	OF DIAG PRIOR TO FINAL IMPRESSION		D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$250*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	DC700*	BASE METAL	ФОГО*
DCE40	PROSTHESIS	#200 *	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$250* \$200*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN	\$300*	D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$300*
D6549	BONDED FIXED PROSTHESIS RESIN RETAINER – FOR RESIN BONDED FIXED	\$85	D6784	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	\$250*
	PROSTHESIS	***	D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE	\$250*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$270*		METAL	·
	SURFACES		D6791	RETAINER CROWN - FULL CAST	\$250*
D6601	RETAINER INLAY - PORCELAIN/CERAMIC	\$270*		PREDOMINANTLY BASE METAL	
D6602*	3/MORE SURFACES	\$185*	D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	\$250*
D0002	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	φιου	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$250*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$185*	D6920	ALLOYS CONNECTOR BAR	\$85
	SURFACES	·	D6930	RECEMENT OR RE-BOND FIXED PARTIAL	\$0 \$0
D6604	RETAINER INLAY - CAST PREDOM BASE METAL	\$185*	D0000	DENTURE	Ψ
	2 SURFACES		D6940	STRESS BREAKER	\$125
D6605	RETAINER INLAY - CAST PREDOM BASE METAL	\$185*	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$60
D6606*	3/>SURFACES	\$185*	ORAL S	URGERY SERVICES	
D0000	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	\$100	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$10
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$185*	D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$10
	SURFACES		D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$30
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2	\$280*		REMOVAL OF BONE AND/OR SECTIONING OF	
	SURFACES			TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC	\$280*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$65
D6610*	3/MORE SURFACES	\$185*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$85
D0010	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	\$100	D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$125
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/>	\$175*	57210	BONY	V120
	SURFACES	·	D7241	REMOVAL IMPACTED TOOTH - COMPLETELY	\$150
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL	\$175*		BONY W/SURG COMP	
	2 SURFACES	* /	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS	\$40
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL	\$175*	D7251	(CUTTING PROCEDURE)	\$150
D6614*	3/>SURFACES RETAINER ONLAY - CAST NOBLE METAL 2	\$175*	DIZJI	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	φ130
50011	SURFACES	V110	D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL	\$175*	D7270	TOOTH REIMPLANTATION AND/OR	\$50
	3/MORE SURFACES			STABILIZATION ACCIDENTLY DISPLACED	
D6624*	RETAINER INLAY - TITANIUM	\$250*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634*	RETAINER ONLAY - TITANIUM	\$250*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$90
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7005	TOOTH TO AID ERUPTION	0.450
D6720*	COMPOSITE PERMANER OF THE PROPERTY OF THE PROP	\$250*	D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D0120	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	φ250	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$60
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$250*	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	\$20
	BASE METAL		D7288	BRUSH BIOPSY	\$20
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$300*	D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	\$40
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7311	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$15
D0754	HIGH NOBLE METAL	ФОГО*	D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$60
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$25
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
	NOBLE METAL	4		(SECONDARY EPITHELIALIZATION)	
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$250*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE	
				ATTACHMENT, REVISION OF SOFT TISSUE	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$100
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$100
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	# 400
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$100
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$35
D1400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$90
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
	1.25 CM	**-	D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$85		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$65	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$65	D9996	ENCOUNTER TELEPENTISTRY ASYMCHRONOLIS	\$0
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$65	D3330	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	ΨΟ
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$35		DENTIST FOR SUBSEQUENT REVIEW	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	\$35	D9999	BROKEN APPOINTMENT	\$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$10	D0000	ADOLESCENT DENTITION	¢1 00E
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	\$1,895
D7961	BUCCAL / LABIAL FRENECTOMY	\$45	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
	(FRENULECTOMY)			MONITOR GROWTH AND DEVELOPMENT	,
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$45	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$45		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$55	D0005	OF RETAINERS)	0.150
D7971	EXCISION OF PERICORONAL GINGIVA	\$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY ETIVE GENERAL SERVICES	\$100		FOR REASONS OTHER THAN COMPLETION OF TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
	ANESTHESIA				
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
D0000	15 MINUTES	^- -			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
D9230	15 MINUTE INCREMENT ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
D3230	NITROUS OXIDE	ΨΟΟ			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
	SEDATION/ANESTHESIA - FIRST 15 MINUTES				
D9243	INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
	SEDATION/ANALGESIA - EACH 15 MINUTE				
D9248	INCREMENT	\$50			
D3240	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND	ΨΟΟ			
	MODERATE SEDATION				
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$10			

¹Additional Prophy within 6 months will be based upon the necessity recommended by the provider.
²Copays listed are also applicable in the specialist office.
For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.
¹If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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LIMITATIONS OF BENEFITS

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		• Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

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

ben	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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.				
6.	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.				
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.				
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).				
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.				
10.	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.				

- 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Contributory 120C/covered dental services

TX D096C

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0		DISEASES - SPECIMEN ANALYSIS	
	REPORT	·	D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0.470	REPORT	00
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	\$0
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	Φ0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	MARG PREP/REPORT	\$0
	IMAGE		D0001	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	ΨΟ
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
	RADIOGRAPHIC IMAGE			DOCUMENTATION, MODERATE	**
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
D0054	IMAGE	*	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	
D0270	RADIOGRAPHIC IMAGE BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0
D0270	BITEWING - SINGLE KADIOGRAPHIC IMAGE BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0 \$0		IMAGE CAPTURE ONLY	
			D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0 \$0	D0700	RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	40
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0	D0707	IMAGE CAPTURE ONLY	\$0
D0330	IMAGES PANORAMIC RADIOGRAPHIC IMAGE	\$0	DOTOT	INTRAORAL-PERIAPICAL RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	φυ
D0330		\$0 \$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	\$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	φυ	20100	IMAGE CAPTURE ONLY	Ψ
D0364	CONE BEAM CT CAPTURE AND	\$25	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
20001	INTERPRETATION WITH LIMITED FIELD OF	ΨLO		RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	
	VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$5
D0365	CONE BEAM CT CAPTURE AND	\$25	PREVEN	ITIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D1110 ¹	PROPHYLAXIS - ADULT	\$0
	OF ONE FULL DENTAL ARCH-MANDIBLE		D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$25		6 MONTHS	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11201	PROPHYLAXIS - CHILD	\$0
D.000=	OF ONE FULL DENTAL ARCH-MAXILLA	***	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
D0367	CONE BEAM CT CAPTURE AND	\$25		MONTHS	
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	TOPICALFLUORIDE VARNISH	\$0
D0368	JAWS CONE BEAM CT CAPTURE AND	\$25	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
Воссо	INTERPRETATION FOR TMJ SERIES INCLUDING	Ψ20		EXCLUDING VARNISH	
	TWO OR MORE EXPOSURES		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
	SPECIMEN TO INCLUDE CULTURE AND		D1351	SEALANT - PER TOOTH	\$8
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
	TRANSMISSION OF WRITTEN REPORT			CARIES RISK PATIENT- PERM TOOTH	
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION – PER TOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$250
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$250
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$250
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$40	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$250
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$40	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$250
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$40	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$250
D1551	RECEM/REBOND BILATERAL SPACE	\$15	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$150
D.1==0	MAINTAINER – MAXIL	A 4-	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$150
D1552	RECEM/REBOND BILATERAL SPACE	\$15	D0700*	INDIRECT	ФО Г О*
D1553	MAINTAINER – MANDIB RECEM/REBOND UNILATERAL SPACE	\$15	D2720* D2721	CROWN - RESIN WITH HIGH NOBLE METAL CROWN - RESIN W/PREDOM BASE METAL	\$250* \$250*
	MAINTAINER/QUAD	***	D2721 D2722*	CROWN - RESIN WITH NOBLE METAL	\$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$300*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$250*
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$15	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$250*
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2752*	METAL CROWN - PORCELAIN FUSED NOBLE METAL	\$250*
D1575	MAINTAINER-MANDIB	\$25	D2753	CROWN PORCELAIN FUSED TO	\$250
פוטוט	DISTAL SHOE SPACE MAINTAINER – FIXED, UNILATERAL/QUAD	φΖΟ		TITANIUM/TITANIUM ALLOYS	,
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$5	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$250*
	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$250*
RESTOR	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$250*
D2140	AMALGAM - ONE SURFACE	\$8	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$250*
	PRIMARY/PERMANENT		D2790*	CROWN - FULL CAST HIGH NOBLE METAL	\$250*
D2150	AMALGAM - TWO SURFACES	\$15	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$250*
D2160	PRIMARY/PERMANENT	\$22	D2792*	CROWN - FULL CAST NOBLE METAL	\$250*
D2100	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	ΨΖΖ	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$250*
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	\$28	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	\$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$10	D2915	RECEMENT OR RE-BOND INDIRECTLY	\$0
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$20	D2920	FABRICATED PREFABRICATED POST & CORE RECEMENT OR RE-BOND CROWN	\$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$30	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$38	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$45	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$50		PRIMARY	, -
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$55	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$85		PERMANENT	
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$95	D2932	PREFABRICATED RESIN CROWN	\$40
D2510	INLAY - METALLIC - ONE SURFACE	\$185	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$40
D2520	INLAY - METALLIC - TWO SURFACES	\$185	D2934	RESIN WINDOW	\$60
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$185	D2304	PREFABRICATED ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	φου
D2542	ONLAY - METALLIC - TWO SURFACES	\$225	D2940	SEDATIVE FILLING	\$0
D2543	ONLAY - METALLIC THREE SURFACES	\$225	D2941	INTERIM THERAPEUTIC RESTORATION –	\$5
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$225 \$250*		PRIMARY DENTITION	
D2610 D2620	INLAY - PORCELAIN/CERAMIC - 1 SURFACE INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250* \$250*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$50
D2630		\$250*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$10
D2030	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	Ψ230	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$50
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$50
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$250*	D2954	TOOTH	\$30
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	\$250*	D23J4	PREFABRICATED POST & CORE ADDITION CROWN	φου

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	RATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962		\$600*		MOLAR	
D2302	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	φουσ	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$50	D3911	INTRAORIFICE BARRIER	\$50
B2011	XST PART DENTURE	ΨΟΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	OONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	\$130
ENDOD	SURFACE LESIONS DNTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$85
		Φ.		TEETH QUAD	,
D3110	PULP CAP - DIRECT	\$5	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$5		PROC/TOOTH	
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$5	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$150
D0004	JUNC	***	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$110
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$30	D4245	APICALLY POSITIONED FLAP	\$165
D2000	TEETH PARTIAL BUILDOTOMY	# 00	D4249	CLIN CROWN LEN - HARD TISSUE	\$150
D3222	PARTIAL PULPOTOMY	\$60	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$355
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$275
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$40	D4263		\$205
D2240	TOOTH	Ф40 Г	D4203	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	ΨΣΟΟ
D3310	ANTERIOR	\$125	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3320	BICUSPID	\$175		NATURAL TOOTH – EACH ADDITIONAL SITE IN	***
D3330	MOLAR	\$325		QUADRANT	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$235
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$85	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$90
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$85		TOOTH (WHEN NOT PERFORMED IN	
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$145		CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$195		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$345	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70	D. 40=0	TOOTH	***
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70	D4322	TOOTH	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	Φ/ 3
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	PROSTHETIC CROWNS	\$75
	MEDICAMENT REPLACEMENT		D4020	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	Ψίδ
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4341	PERIODONTAL SCAL & ROOT PLAN	\$55t
	TREATMENT			4/>TEETH-QUAD	,,,,,
D3410	APICOECTOMY SURG - ANT	\$95	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$50t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$30
D3425	APICOECTOMY SURG - MOLAR	\$95		MODERATE OR SEVERE GINGIVAL	
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION - FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$55t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900		ON A SUBSEQUENT VISIT	
D3471	SURGICAL REPAIR OF ROOT RESORPTION -	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE	\$65t
D3472	ANTERIOR SURGICAL REPAIR OF ROOT RESORPTION –	\$95		INTO DISEASED CREVICULAR TISSUE, PER TOOTH	
B	PREMOLAR		D4910	PERIODONTAL MAINTENANCE	\$40
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	\$95	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3501	MULAR SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
_ 500 1	APICOECTOMY OR REPAIR ROOT	Ψ200	REMOV	ABLE PROSTHODONTIC SERVICES	
	RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$350*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$40*
D5120	COMPLETE DENTURE - MANDIBULAR	\$350*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$400*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$400*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$325*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$325*	DE740	MANDIBULAR	↑7 Г*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$425*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$75*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$425*	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$75*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$145*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$75* \$75*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$75 \$75
	MATERIALS, RESTS AND TEETH)		D5725	RELINE CMPL MAXIL DENTURE (DIRECT)	\$75 \$55*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$155*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$55*
D5223	MATERIALS, RESTS AND TEETH)	\$145*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$55*
DOZZO	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ψ140	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$75*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$75*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$75*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$75*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$155*	D5765	SOFT LINER FOR COMPLETE OR PART	\$20
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	ΨΣΟ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$145*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$155*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$425*	D5850	TISSUE CONDITIONING MAXILLARY	\$20
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$425*	D5851	TISSUE CONDITIONING MANDIBULAR	\$20
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$145	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$155	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE	****	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$300*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$75
D5283	MAXILLARY	\$300*		DENTURE (PER ARCH)	
D0200	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	Ψ300	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$425	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	****
D5286	REMOVABLE UNILATERAL PARTIAL	\$425	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$10	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$10	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖΙΟ
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$10	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$10		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$35*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$35*		CROWN	
D5520	MAXILLARY PERI ACE MISSING/PROVEN TEETLY COMPLETE	\$35*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	ΨΟΟ	Denen	METAL CROWN (HIGH NOBLE METAL)	¢640
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$35*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$35*		METAL CROWN (NOBLE METAL)	,,,,,
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$35*		(HIGH NOBLE METAL)	
DEGOO	MANDIBULAR	ሰ ጋርታ	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$35*	D0004	(PREDOMINATELY BASE METAL)	4-4-
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$35*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
_ 5550	TOOTH	400	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$35*	50000	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	φοσο
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$40*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLAN	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)		D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	\$630	D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	\$275
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	\$245
D6072*	METAL) ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	\$635	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	\$875
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	\$595	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH –	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		MANDIBULAR	
D6075	METAL FPD (NOBLE METAL) IMPLANT SUPPORTED RETAINER FOR CERAMIC	\$615	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH	\$875
D6076*	FPD IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	- MAXILLARY IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6077*	PORCELAIN FUSED TO HIGH NOBLE ALLOYS IMPLANT SUPPORTED RETAINER FOR METAL	\$630		DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED,	\$40	D6121	TO TITANIUM/TITANIUM ALLOYS IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS IMPLANT SUPPT RETAINER FOR METAL	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE	\$180t	D6123	FPD-NOBLE ALLOYS IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE		D0120	FPD-TITANIUM/TITANIUM ALLOYS	φοσσ
	IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	\$145
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
D0003	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	FUSED TO TITANIUM/TITANIUM ALLOYS PROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$250*
	ALLOYS		D6211 D6212*	PONTIC - CAST PREDOM BASE METAL PONTIC - CAST NOBLE METAL	\$250* \$250*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	\$165	D6212*	PONTIC - CAST NOBLE METAL PONTIC - TITANIUM AND TITANIUM ALLOYS	\$250*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$250*
	SEMI-PRECISION/PRECISION ATTCHMT OF IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	\$250*
	ATTCHMT		D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$250*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	\$60	D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$250*
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	D6245	PONTIC - PORCELAIN/CERAMIC	\$300*
D6094*	SUPPORTED FIXED PARTIAL DENTURE ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250*
	AND TITANIUM ALLOYS	¥•	D6251	PONTIC RESIN W/PREDOM BASE METAL	\$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$250*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED PI	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$250*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$250*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	D0700*	BASE METAL	фо го +
DCE 40	PROSTHESIS	#200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$250* \$200*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC RETAINER CROWN - 3/4 TITANIUM/TITANIUM	\$300* \$250*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	ALLOYS RETAINER CROWN - 5/4 THANIOW/THANIOW ALLOYS	\$250*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$270*		METAL	
D6601	SURFACES RETAINER INLAY - PORCELAIN/CERAMIC	\$270*	D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	\$250*
	3/MORE SURFACES		D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	\$250*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	\$185*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	\$250*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$185*	D6920	CONNECTOR BAR	\$85
D6604	SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$185*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	\$0
D6605	2 SURFACES	\$185*	D6940	STRESS BREAKER	\$125
D0003	RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$100	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$60
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$185*		JRGERY SERVICES	\$10
D0007*	SURFACES	0405*	D7111 D7140	XTRCT CORONAL REMNANTS PRIMARY TOOTH EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$10 \$10
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	\$185*	D7140	EXTRACTION, ERUPTED TOOTH REQUIRING	\$30
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$280*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	,,,
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC	\$280*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$65
D6610*	3/MORE SURFACES RETAINER ONLAY - CAST HI NOBLE METAL 2	\$185*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$85
	SURFACES		D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$125
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$175*	D7241	BONY REMOVAL IMPACTED TOOTH - COMPLETELY	\$150
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	\$175*	D7250	BONY W/SURG COMP REMOVAL OF RESIDUAL TOOTH ROOTS	\$40
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$175*	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$175*	57201	REMOVAL	ψ100
	SURFACES		D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	\$175*	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$50
D6624*	RETAINER INLAY - TITANIUM	\$250*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634* D6710	RETAINER ONLAY - TITANIUM	\$250* \$185*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$90
D07 10	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	\$105	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE	\$250*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$60
D6721	METAL RETAINER CROWN - RESIN PREDOMINANTLY	\$250*	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	\$20
	BASE METAL		D7288	BRUSH BIOPSY	\$20
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$300*	D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	\$40
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	\$250*	D7311 D7320	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$15 \$60
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7320	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$25
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
D0702	NOBLE METAL	ΨΣΟΟ		(SECONDARY EPITHELIALIZATION)	
D6753	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$250*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	\$670

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$100
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$100
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	# 400
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$100
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$35
D1400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$90
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
	1.25 CM	**-	D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$85		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$65	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$65	D9996	ENCOUNTER TELEPENTISTRY ASYMCHRONOLIS	\$0
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$65	D3330	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	ΨΟ
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$35		DENTIST FOR SUBSEQUENT REVIEW	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	\$35	D9999	BROKEN APPOINTMENT	\$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$10	D0000	ADOLESCENT DENTITION	¢1 00E
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	\$1,895
D7961	BUCCAL / LABIAL FRENECTOMY	\$45	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
	(FRENULECTOMY)			MONITOR GROWTH AND DEVELOPMENT	,
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$45	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$45		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$55	D0005	OF RETAINERS)	0.150
D7971	EXCISION OF PERICORONAL GINGIVA	\$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY ETIVE GENERAL SERVICES	\$100		FOR REASONS OTHER THAN COMPLETION OF TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
	ANESTHESIA				
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
D0000	15 MINUTES	^- -			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
D9230	15 MINUTE INCREMENT ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
D3230	NITROUS OXIDE	ΨΟΟ			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
	SEDATION/ANESTHESIA - FIRST 15 MINUTES				
D9243	INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
	SEDATION/ANALGESIA - EACH 15 MINUTE				
D9248	INCREMENT	\$50			
D3240	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND	ΨΟΟ			
	MODERATE SEDATION				
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$10			

'Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

'Copays listed are also applicable in the specialist office.

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

'If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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LIMITATIONS OF BENEFITS

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		• Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

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

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
10.	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.Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Contributory 130/covered dental services

TX D095N

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0405	DISEASES - SPECIMEN ANALYSIS	40
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0470	REPORT	Φ0
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	\$0
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	ΦΟ
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	MARG PREP/REPORT CARIES RISK ASSESSMENT AND	\$0
	IMAGE		B0001	DOCUMENTATION, LOW	Ψ
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
	RADIOGRAPHIC IMAGE			DOCUMENTATION, MODERATE	**
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
D0054	IMAGE	40	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	
D0270	RADIOGRAPHIC IMAGE BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0
		·		IMAGE CAPTURE ONLY	
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0		RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0	D0707	IMAGE CAPTURE ONLY	Φ0
D0000	IMAGES	Φ0	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0	D0708	IMAGE-IMAGE CAPTURE ONLY	\$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0700	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE- IMAGE CAPTURE ONLY	ΨΟ
D0364	ACQUISITION, MEASUREMENT AND ANALYSIS	\$20	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
D0304	CONE BEAM CT CAPTURE AND	ΨΖΟ		RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	**
	INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$0
D0365	CONE BEAM CT CAPTURE AND	\$20	PREVEN	ITIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW	•	D1110 ¹	PROPHYLAXIS - ADULT	\$0
	OF ONE FULL DENTAL ARCH-MANDIBLE		D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$25	BIIIO	6 MONTHS	ΨΣΟ
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11201	PROPHYLAXIS - CHILD	\$0
	OF ONE FULL DENTAL ARCH-MAXILLA		D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
D0367	CONE BEAM CT CAPTURE AND	\$25		MONTHS	,
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	TOPICALFLUORIDE VARNISH	\$0
	JAWS	40-	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
D0368	CONE BEAM CT CAPTURE AND	\$25		EXCLUDING VARNISH	·
	INTERPRETATION FOR TMJ SERIES INCLUDING		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	TWO OR MORE EXPOSURES INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D0331		\$0 \$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
DU+14	LABORATORY PROCESSING OF MICROBIAL	φυ	D1351	SEALANT - PER TOOTH	\$8
	SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
	TRANSMISSION OF WRITTEN REPORT		2.002	CARIES RISK PATIENT- PERM TOOTH	ΨIO
D0445	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0415					,
D0415 D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$250
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$250
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$250
D1520	SPACE MAINTAINER -	\$40	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$250
D1526	REMOVABLE-UNILATERAL/QUAD SPACE MAINTAINER - REMOVABLE - BILATERAL,	\$40	D2663	ONLAY - RESIN - BASED COMPOSITE - 3	\$250
D1527	MAXILLARY SPACE MAINTAINER - REMOVABLE - BILATERAL,	\$40	D2664	SURFACES ONLAY - RESIN - BASED COMPOSITE - 4/>	\$250
D1551	MANDIBULAR RECEM/REBOND BILATERAL SPACE	\$15	D2710	SURFACES CROWN - RESIN - BASED COMPOSITE INDIRECT	\$150
	MAINTAINER – MAXIL		D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$150
D1552	RECEM/REBOND BILATERAL SPACE	\$15	D2720*	INDIRECT CROWN - RESIN WITH HIGH NOBLE METAL	\$250*
D1553	MAINTAINER – MANDIB RECEM/REBOND UNILATERAL SPACE	\$15	D2720 D2721	CROWN - RESIN WITH HIGH NOBLE METAL CROWN - RESIN W/PREDOM BASE METAL	\$250*
	MAINTAINER/QUAD	***	D2721 D2722*	CROWN - RESIN WITH NOBLE METAL	\$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$300*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$250*
D1557	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$250*
D1558	MAINTAINER-MAXIL	\$15		METAL METAL	,
D 1330	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	φισ	D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$250*
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED,	\$25	D2753	CROWN PORCELAIN FUSED TO	\$250
	UNILATERAL/QUAD		D0700*	TITANIUM/TITANIUM ALLOYS	* 050*
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$0	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$250*
DECTOR	REPORT		D2781 D2782*	CROWN - 3/4 CAST PREDOM BASE METAL	\$250*
	ATIVE SERVICES	40	D2782 D2783	CROWN - 3/4 CAST NOBLE METAL CROWN - 3/4 PORCELAIN/CERAMIC	\$250* \$250*
D2140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	\$0	D2703 D2790*	CROWN - 5/4 PORCELAIN/CERAWIC CROWN - FULL CAST HIGH NOBLE METAL	\$250*
D2150	AMALGAM - TWO SURFACES	\$0	D2790 D2791	CROWN - FULL CAST PREDOM BASE METAL	\$250*
	PRIMARY/PERMANENT	**	D2792*	CROWN - FULL CAST NOBLE METAL	\$250*
D2160	AMALGAM - 3 SURFACES	\$0	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$250*
D2161	PRIMARY/PERMAMENT AMALGAM - FOUR/MORE SURFACES	\$0	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$0
	PRIMARY/PERMANENT		D2915	OR PART COV REST RECEMENT OR RE-BOND INDIRECTLY	\$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0	220.0	FABRICATED PREFABRICATED POST & CORE	**
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0	D2920	RECEMENT OR RE-BOND CROWN	\$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$40	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$40		PRIMARY	
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$45	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$75 \$75	D2932	PERMANENT PREFABRICATED RESIN CROWN	\$40
D2394 D2510	RESIN COMPOSITE - 4/MORE SURFACES POST INLAY - METALLIC - ONE SURFACE	\$75 \$175	D2933		\$40 \$40
D2510	INLAY - METALLIC - ONE SURFACE INLAY - METALLIC - TWO SURFACES	\$175 \$175	D2300	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	Ψτο
D2530	INLAY - METALLIC - 1/WO SURFACES	\$175 \$175	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$225		STEEL CROWN - PRIMARY	
D2543	ONLAY - METALLIC THREE SURFACES	\$225	D2940	SEDATIVE FILLING	\$0
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$225	D2941	INTERIM THERAPEUTIC RESTORATION -	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$250*	D0050	PRIMARY DENTITION	^- ^
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$50 \$40
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$250*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$10 \$40
	SURFACES	·	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$40 \$40
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	D2953	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	\$40
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$250*	D2954	PREFABRICATED POST & CORE ADDITION	\$25
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$250*	-	CROWN	,

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962	LABIAL VENEER (PORCELAIN LAMINATE) -	\$600*	D2040	MOLAR	Ф4 Г
	INDIRECT	, , , ,	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$50	D3911	INTRAORIFICE BARRIER	\$40
	XST PART DENTURE		D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST CONTIC SERVICES	\$15
D2980	CROWN REPAIR	\$35			6445
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$115
	SURFACE LESIONS		D4211	TEETH QUAD	\$80
	ONTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	ΨΟΟ
D3110	PULP CAP - DIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$0		PROC/TOOTH	, ,
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$150
D0004	JUNC	400	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$95
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$30	D4245	APICALLY POSITIONED FLAP	\$165
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$145
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$325
D3240		\$40 \$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$225
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	Ψ40	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	ANTERIOR	\$95		NATURAL TOOTH - FIRST SITE IN QUADRANT	
D3320	BICUSPID	\$175	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3330	MOLAR	\$305		NATURAL TOOTH - EACH ADDITIONAL SITE IN	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D 10=0	QUADRANT	***
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$85	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$225
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$85	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$85
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$115		TOOTH (WHEN NOT PERFORMED IN	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$175		CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$300	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70		TOOTH	·
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70		ТООТН	
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	\$75
D3356		\$65		PROSTHETIC CROWNS	
D3330	PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT	ΨΟΟ	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4244	PROSTHETIC CROWNS	¢45+
	TREATMENT		D4341	PERIODONTAL SCAL & ROOT PLAN	\$45t
D3410	APICOECTOMY SURG - ANT	\$95	D4342	4/>TEETH-QUAD PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$45t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$25
D3425	APICOECTOMY SURG - MOLAR	\$95	Бчочо	MODERATE OR SEVERE GINGIVAL	Ψ20
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION – FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$50t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900		ON A SUBSEQUENT VISIT	
D3471	SURGICAL REPAIR OF ROOT RESORPTION -	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL	\$55t
	ANTERIOR			AGENTS VIA A CONTROLLED RELEASE VEHICLE	
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$95		INTO DISEASED CREVICULAR TISSUE, PER	
	PREMOLAR		D4910	TOOTH PERIODONTAL MAINTENANCE	\$30
D3473	SURGICAL REPAIR OF ROOT RESORPTION -	\$95	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3E04	MOLAR	ተ ጋር ር	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250		ABLE PROSTHODONTIC SERVICES	40
	APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$275*
	NEOONI I-MITENION		20110	JOIN EETE DEITIONE IN VICE IN	ΨΖΙΟ

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$30*
D5120	COMPLETE DENTURE - MANDIBULAR	\$275*		TOOTH	·
D5130	IMMEDIATE DENTURE - MAXILLARY	\$315*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$315*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$250*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$250*	D==40	MANDIBULAR	40.5 *
D5213	MAX PART DENTUR-CAST METL W/RSN	\$325*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$65*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$325*	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$65*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$115*	D5720	REBASE MAXILLARY PARTIAL DENTURE	\$65*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING	•	D5721	REBASE MANDIBULAR PARTIAL DENTURE	\$65*
	MATERIALS, RESTS AND TEETH)		D5725	REBASE HYBRID PROSTHESIS	\$65
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$115*	D5730	RELINE CMPL MAXIL DENTURE (DIRECT)	\$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE CMPL MAND DENTURE (DIRECT)	\$55*
D=000	MATERIALS, RESTS AND TEETH)	A.1.=	D5740	RELINE MAXIL PART DENTURE (DIRECT)	\$55*
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$115*	D5741	RELINE MAND PART DENTURE (DIRECT)	\$55*
	CAST METAL FRAMEWORK WITH RESIN		D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$75*
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5751	RELINE CMPL MAND DENTURE (INDIRECT)	\$75*
	TEETH)		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$75*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$115*	D5761	RELINE MAND PART DENTURE (INDIRECT)	\$75*
	CAST METAL FRAMEWORK WITH RESIN		D5765	SOFT LINER FOR COMPLETE OR PART	\$20
	DENTURE BASES (INCLUDING		D.F.0.00	REMOVABLE DENTURE-INDIRECT	0445*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$115*
DEOOL	TEETH)	ф 20 г *	D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$115*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$325*	D5850	TISSUE CONDITIONING MAXILLARY	\$20
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$325*	D5851	TISSUE CONDITIONING MANDIBULAR	\$20
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$115	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
D5228	BASE IMMEDIATE MANDIBULAR PARTIAL	\$115	D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
DOZZO	DENTURE-FLEX BASE	ΨΠΟ	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$275*	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
	MAXILLARY		D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$65
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$275*	IMDI AN	DENTURE (PER ARCH) T SERVICES	
	MANDIBULAR				\$975
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$325	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
D=000	FLEX BASE/QUAD	****	D6013	ENDOSTEAL IMPLANT SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
D5286	REMOVABLE UNILATERAL PARTIAL	\$325	D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	DENTURE-RESIN/QUAD	\$10	20000	BAR	ψοσο
D5410	ADJUST COMPLETE DENTURE - MAXILLARY ADJUST COMPLETE DENTURE - MANDIBULAR	\$10 \$10	D6056	PREFABRICATED ABUTMENT - INCLUDES MOD	\$275
D5411	ADJUST PARTIAL DENTURE - MAXILLARY	\$10 \$10		AND PLACEMENT	
D5421	ADJUST PARTIAL DENTURE - MANDIBULAR	\$10	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422				PLACEMENT	
	REPAIR BROKEN COMPLETE DENTURE BASE	\$30*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$30*	D00=0+	CROWN	A0=0
D5520	MAXILLARY REPLACE MISSING/BROKEN TEETH - COMPLETE	\$30*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D0020	DENTURE	φοσ	D6060	METAL CROWN (HIGH NOBLE METAL)	\$610
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$30*	D0000	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	φοιο
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$30*	2000.	METAL CROWN (NOBLE METAL)	Ų 000
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$30*		(HIGH NOBLE METAL)	
D=005	MANDIBULAR	***	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$30*		(PREDOMINATELY BASE METAL)	
DEESO	MAXILLARY	¢ኃቦ*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	\$30*	Dooos	(NOBLE METAL)	***
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$30*	D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC	\$690
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$30*		CROWN	
_ 5556		ΨΟΟ			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)		20.02	DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	ΨΞ. ΰ
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH –	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	,,,,
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40		TO TITANIUM/TITANIUM ALLOYS	
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	φοσο
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	*****	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	,
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$250*
20000	ALLOYS	ψοιο	D6211	PONTIC - CAST PREDOM BASE METAL	\$250*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$250*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$250*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$250*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$250*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$250*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$250*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$300*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$250*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED PI	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$250*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$250*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	DC700*	BASE METAL	ФОГО*
D0540	PROSTHESIS	*200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$250*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC RETAINER CROWN - 3/4 TITANIUM/TITANIUM	\$300* \$250*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	ALLOYS RETAINER CROWN - 5/4 THANIOW/THANIOW/ ALLOYS	\$250*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$270*		METAL	
D6601	SURFACES	\$270*	D6791	RETAINER CROWN - FULL CAST	\$250*
D0001	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	Ψ210	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$250*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	\$175*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	\$250*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$175*	D6920	CONNECTOR BAR	\$85
Decov	SURFACES	¢175*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL	\$0
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	\$175*	D6940	DENTURE STRESS BREAKER	\$125
D6605	RETAINER INLAY - CAST PREDOM BASE METAL	\$175*	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$125 \$60
	3/>SURFACES			JRGERY SERVICES	ΨΟΟ
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$175*	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$8
D6607*	SURFACES RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$175*	D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$8
2000.	SURFACES	4	D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$30
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$280*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$280*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$55
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2	\$175*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$85
D6611*	SURFACES	\$175*	D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	\$125
	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES		D7241	REMOVAL IMPACTED TOOTH - COMPLETELY	\$150
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	\$175*	D7250	BONY W/SURG COMP REMOVAL OF RESIDUAL TOOTH ROOTS	\$40
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$175*	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$175*		REMOVAL	
	SURFACES	.	D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	\$175*	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$50
D6624*	RETAINER INLAY - TITANIUM	\$250*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634*	RETAINER ONLAY - TITANIUM	\$250*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$90
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	\$185*	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE	\$250*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$60
	METAL		D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$250*		COLLECTION	
D6722*	BASE METAL RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$300*	D7290 D7310	SURGICAL REPOSITIONING OF TEETH	\$75 \$40
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$40 \$15
	HIGH NOBLE METAL		D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$60
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$25
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
	NOBLE METAL		רבטרי	(SECONDARY EPITHELIALIZATION)	<u> </u>
D6753	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$250*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	\$670

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	·
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110		ARCH	
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
	1.25 CM		D0054	ARCH	400
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$100	D9951	OCCLUSAL ADJUSTMENT - LIMITED	\$30
D7464	OR TUMOR - LESION DIAMETER UP TO 1.25 CM	¢10E	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$90
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	1.25 CM		D9975	PERFORMED IN OFFICE	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$85	D3373	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	Ψ123
D7472	REMOVAL OF TORUS PALATINUS	\$65	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$65		ENCOUNTER ENCOUNTER	•
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$65	D9996	TELEDENTISTRY - ASYNCHRONOUS;	\$0
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$35		INFORMATION STORED AND FORWARDED TO	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS	\$35		DENTIST FOR SUBSEQUENT REVIEW	
	COMPLICATED	, , ,	D9999	BROKEN APPOINTMENT	\$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	44.005
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$10	D0000	ADOLESCENT DENTITION	¢1 905
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D8090	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7961	BUCCAL / LABIAL FRENECTOMY	\$45	D8660	ADULT DENTITION PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
	(FRENULECTOMY)		20000	MONITOR GROWTH AND DEVELOPMENT	Ψ200
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$45	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$45		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$55		OF RETAINERS)	
D7971	EXCISION OF PERICORONAL GINGIVA	\$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	\$100		FOR REASONS OTHER THAN COMPLETION OF	
ADJUNC	TIVE GENERAL SERVICES		D0000	TREATMENT	#450
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS,TRACING, PHOTOS, AND MODELS)	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		WODELO	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	\$0			
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	\$150			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	\$75			
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	\$30			
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	\$140			
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	\$70			
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	\$50			
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$10			

¹Additional Prophy within 6 months will be based upon the necessity recommended by the provider.
²Copays listed are also applicable in the specialist office.
For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.
*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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LIMITATIONS OF BENEFITS

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		• Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

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

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

- 10. 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.
- 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Voluntary 130C/covered dental services

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0		DISEASES - SPECIMEN ANALYSIS	
20.00	REPORT	**	D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT	, -	D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5		REPORT	
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	00
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	\$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	MARG PREP/REPORT	\$0
	IMAGE		D0601	CARIES RISK ASSESSMENT AND	Φ0
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	DOCUMENTATION, LOW	\$0
	RADIOGRAPHIC IMAGE		D0002	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	ΨΟ
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0	20000	DOCUMENTATION, HIGH	Ψ0
	IMAGE		D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	, ,
	RADIOGRAPHIC IMAGE		D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE –	\$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0		IMAGE CAPTURE ONLY	
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0		RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0		IMAGE CAPTURE ONLY	
	IMAGES		D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0		IMAGE-IMAGE CAPTURE ONLY	
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	\$0
	ACQUISITION, MEASUREMENT AND ANALYSIS		D0700	IMAGE CAPTURE ONLY	# 0
D0364	CONE BEAM CT CAPTURE AND	\$20	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
	INTERPRETATION WITH LIMITED FIELD OF		D0999	RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY OFFICE VISIT FEE - PER VISIT	\$5
D0365	VIEW-LESS THAN ONE WHOLE JAW	\$20		ITIVE SERVICES	Ψ
D0303	CONE BEAM CT CAPTURE AND	φ∠∪			40
	INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE		D1110¹	PROPHYLAXIS - ADULT	\$0
D0366	CONE BEAM CT CAPTURE AND	\$25	D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
20000	INTERPRETATION WITH LIMITED FIELD OF VIEW	4- 0	D11201	6 MONTHS	¢ο
	OF ONE FULL DENTAL ARCH-MAXILLA		D11201	PROPHYLAXIS - CHILD	\$0 \$25
D0367	CONE BEAM CT CAPTURE AND	\$25	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	MONTHS TOPICALFLUORIDE VARNISH	\$0
	JAWS				
D0368	CONE BEAM CT CAPTURE AND	\$25	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
	INTERPRETATION FOR TMJ SERIES INCLUDING		D1310	EXCLUDING VARNISH NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
	TWO OR MORE EXPOSURES		D1310	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0 \$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5			
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0 \$0
	SPECIMEN TO INCLUDE CULTURE AND		D1351	SEALANT - PER TOOTH	\$8
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
D0415	TRANSMISSION OF WRITTEN REPORT COLLECT MICROORGANISMS CULT & SENS	\$0	D1252	CARIES RISK PATIENT- PERM TOOTH	фr
			D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10 \$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION – PER TOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$250
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$250
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$250
D1520	SPACE MAINTAINER -	\$40	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$250
D1526	REMOVABLE-UNILATERAL/QUAD SPACE MAINTAINER - REMOVABLE - BILATERAL,	\$40	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$250
D1527	MAXILLARY SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$40	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$250
D1551	RECEM/REBOND BILATERAL SPACE	\$15	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$150
D1550	MAINTAINER – MAXIL	\$15	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$150
D1552	RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB	\$15	D2720*	INDIRECT CROWN - RESIN WITH HIGH NOBLE METAL	\$250*
D1553	RECEM/REBOND UNILATERAL SPACE	\$15	D2721	CROWN - RESIN W/PREDOM BASE METAL	\$250*
	MAINTAINER/QUAD		D2722*	CROWN - RESIN WITH NOBLE METAL	\$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$300*
D4557	MAINTAINER/QUAD	045	D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$250*
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$15	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$250*
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2752*	METAL CROWN - PORCELAIN FUSED NOBLE METAL	\$250*
D1575	MAINTAINER-MANDIB DISTAL SHOE SPACE MAINTAINER – FIXED,	\$25	D2753	CROWN PORCELAIN FUSED TO	\$250
	UNILATERAL/QUAD			TITANIUM/TITANIUM ALLOYS	
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$5	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$250*
	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$250*
	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$250*
D2140	AMALGAM - ONE SURFACE	\$0	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$250*
D2150	PRIMARY/PERMANENT	\$0	D2790*	CROWN - FULL CAST HIGH NOBLE METAL	\$250*
D2130	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	Φ0	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$250*
D2160	AMALGAM - 3 SURFACES	\$0	D2792*	CROWN - FULL CAST NOBLE METAL	\$250*
	PRIMARY/PERMAMENT		D2794* D2910	CROWN - TITANIUM AND TITANIUM ALLOYS RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$250* \$0
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	\$0		OR PART COV REST	
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0	D2915	RECEMENT OR RE-BOND INDIRECTLY	\$0
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0	D2020	FABRICATED PREFABRICATED POST & CORE RECEMENT OR RE-BOND CROWN	¢ο
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2920 D2921		\$0 \$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2921 D2929	REATTACHMENT OF TOOTH FRAGMENT PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$40	D2929 D2930		\$25
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$40	D2330	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	ΨΖΟ
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$45	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$75		PERMANENT	
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$75	D2932	PREFABRICATED RESIN CROWN	\$40
D2510	INLAY - METALLIC - ONE SURFACE	\$175	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$40
D2520	INLAY - METALLIC - TWO SURFACES	\$175		RESIN WINDOW	
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$175	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$225	D2940	STEEL CROWN - PRIMARY SEDATIVE FILLING	\$0
D2543	ONLAY - METALLIC THREE SURFACES	\$225	D2941		\$5
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$225	22071	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	ΨΟ
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$250*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$50
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$10
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$250*	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$40
D2642	SURFACES ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$40
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$250*	D00=1	ТООТН	A
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$250*	D2954	PREFABRICATED POST & CORE ADDITION CROWN	\$25

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962	LABIAL VENEER (PORCELAIN LAMINATE) -	\$600*	D2040	MOLAR	Ф4 Г
	INDIRECT	, , , ,	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$50	D3911	INTRAORIFICE BARRIER	\$40
	XST PART DENTURE		D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST CONTIC SERVICES	\$15
D2980	CROWN REPAIR	\$35			6445
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$115
	SURFACE LESIONS		D4211	TEETH QUAD	\$80
	ONTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	ψΟΟ
D3110	PULP CAP - DIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$0		PROC/TOOTH	, ,
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$150
D0004	JUNC	400	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$95
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$30	D4245	APICALLY POSITIONED FLAP	\$165
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$145
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$325
D3240		\$40 \$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$225
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	Ψ40	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	ANTERIOR	\$95		NATURAL TOOTH - FIRST SITE IN QUADRANT	
D3320	BICUSPID	\$175	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3330	MOLAR	\$305		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D 10=0	QUADRANT	***
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$85	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$225
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$85	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$85
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$115		TOOTH (WHEN NOT PERFORMED IN	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$175		CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$300	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70		TOOTH	·
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70		ТООТН	
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	\$75
D3356		\$65		PROSTHETIC CROWNS	
D0000	PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT	ΨΟΟ	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4244	PROSTHETIC CROWNS	¢45+
	TREATMENT		D4341	PERIODONTAL SCAL & ROOT PLAN	\$45t
D3410	APICOECTOMY SURG - ANT	\$95	D4342	4/>TEETH-QUAD PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$45t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$25
D3425	APICOECTOMY SURG - MOLAR	\$95	Бчочо	MODERATE OR SEVERE GINGIVAL	ΨΣΟ
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION – FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$50t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900		ON A SUBSEQUENT VISIT	
D3471	SURGICAL REPAIR OF ROOT RESORPTION -	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL	\$55t
	ANTERIOR			AGENTS VIA A CONTROLLED RELEASE VEHICLE	
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$95		INTO DISEASED CREVICULAR TISSUE, PER	
	PREMOLAR		D4910	TOOTH PERIODONTAL MAINTENANCE	\$30
D3473	SURGICAL REPAIR OF ROOT RESORPTION -	\$95	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3E04	MOLAR	ተ ጋር ር	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250		ABLE PROSTHODONTIC SERVICES	40
	APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$275*
	NEOONI I-MITENION		20110	JOIN EETE DEITIONE IN VICE IN	ΨΖΙΟ

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$30*
D5120	COMPLETE DENTURE - MANDIBULAR	\$275*		TOOTH	,
D5130	IMMEDIATE DENTURE - MAXILLARY	\$315*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$315*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$250*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$250*	D==40	MANDIBULAR	40.5 *
D5213	MAX PART DENTUR-CAST METL W/RSN	\$325*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$65*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$325*	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$65*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$115*	D5720	REBASE MAXILLARY PARTIAL DENTURE	\$65*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING	•	D5721	REBASE MANDIBULAR PARTIAL DENTURE	\$65*
	MATERIALS, RESTS AND TEETH)		D5725	REBASE HYBRID PROSTHESIS	\$65
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$115*	D5730	RELINE CMPL MAXIL DENTURE (DIRECT)	\$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE CMPL MAND DENTURE (DIRECT)	\$55*
D=000	MATERIALS, RESTS AND TEETH)	A445+	D5740	RELINE MAXIL PART DENTURE (DIRECT)	\$55*
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$115*	D5741	RELINE MAND PART DENTURE (DIRECT)	\$55*
	CAST METAL FRAMEWORK WITH RESIN		D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$75*
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5751	RELINE CMPL MAND DENTURE (INDIRECT)	\$75*
	TEETH)		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$75*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$115*	D5761	RELINE MAND PART DENTURE (INDIRECT)	\$75*
	CAST METAL FRAMEWORK WITH RESIN		D5765	SOFT LINER FOR COMPLETE OR PART	\$20
	DENTURE BASES (INCLUDING		D.F.0.00	REMOVABLE DENTURE-INDIRECT	0445*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$115*
DEOOL	TEETH)	#20 F*	D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$115*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$325*	D5850	TISSUE CONDITIONING MAXILLARY	\$20
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$325*	D5851	TISSUE CONDITIONING MANDIBULAR	\$20
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$115	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
D5228	BASE IMMEDIATE MANDIBULAR PARTIAL	\$115	D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
DOZZO	DENTURE-FLEX BASE	ΨΠΟ	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$275*	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
	MAXILLARY		D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$65
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$275*	IMDI AN	DENTURE (PER ARCH) T SERVICES	
	MANDIBULAR		D6010		\$975
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$325	D0010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	φ9/3
D5000	FLEX BASE/QUAD	4005	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
D5286	REMOVABLE UNILATERAL PARTIAL	\$325	D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	DENTURE-RESIN/QUAD ADJUST COMPLETE DENTURE - MAXILLARY	\$10	20000	BAR	Ų.
D5410	ADJUST COMPLETE DENTURE - MANDIBULAR	\$10 \$10	D6056	PREFABRICATED ABUTMENT - INCLUDES MOD	\$275
D5411	ADJUST PARTIAL DENTURE - MAXILLARY	\$10 \$10		AND PLACEMENT	
D5421	ADJUST PARTIAL DENTURE - MANDIBULAR	\$10 \$10	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422				PLACEMENT	
	REPAIR BROKEN COMPLETE DENTURE BASE	\$30* \$30*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$30*	D00=0+	CROWN	A0=0
D5520	MAXILLARY REPLACE MISSING/BROKEN TEETH - COMPLETE	\$30*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D0020	DENTURE	ΨΟΟ	D6060	METAL CROWN (HIGH NOBLE METAL)	\$610
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$30*	D0000	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	φ010
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$30*	2000.	METAL CROWN (NOBLE METAL)	Ų 000
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$30*		(HIGH NOBLE METAL)	
D=005	MANDIBULAR	***	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$30*		(PREDOMINATELY BASE METAL)	
DEGOO	MAXILLARY	ቀኃቦ*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	\$30*		(NOBLE METAL)	***
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$30*	D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC	\$690
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$30*		CROWN	
_ 5556		ΨΟΟ			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)		20.02	DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	Ψ=. σ
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH –	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	,
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40		TO TITANIUM/TITANIUM ALLOYS	****
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	ψΟΟΟ
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	,	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$250*
20000	ALLOYS	ψοιο	D6211	PONTIC - CAST PREDOM BASE METAL	\$250*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$250*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$250*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$250*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$250*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$250*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$250*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$300*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$250*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED P	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$250*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT	\$160		METAL	
	OF DIAG PRIOR TO FINAL IMPRESSION		D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$250*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	DC700*	BASE METAL	₾ 0.E0*
DCE40	PROSTHESIS	#200 *	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$250*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN	\$300*	D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$300*
D6549	BONDED FIXED PROSTHESIS RESIN RETAINER – FOR RESIN BONDED FIXED	\$85	D6784	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	\$250*
	PROSTHESIS	***	D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE	\$250*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$270*		METAL	·
	SURFACES		D6791	RETAINER CROWN - FULL CAST	\$250*
D6601	RETAINER INLAY - PORCELAIN/CERAMIC	\$270*		PREDOMINANTLY BASE METAL	
D6602*	3/MORE SURFACES	\$175*	D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	\$250*
D0002	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	φ1/3	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$250*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$175*	D6920	ALLOYS CONNECTOR BAR	\$85
	SURFACES	·	D6930	RECEMENT OR RE-BOND FIXED PARTIAL	\$0 \$0
D6604	RETAINER INLAY - CAST PREDOM BASE METAL	\$175*	D0000	DENTURE	Ψ
	2 SURFACES		D6940	STRESS BREAKER	\$125
D6605	RETAINER INLAY - CAST PREDOM BASE METAL	\$175*	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$60
D6606*	3/>SURFACES	\$175*	ORAL S	URGERY SERVICES	
D0000	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	\$175	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$8
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$175*	D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$8
	SURFACES		D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$30
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2	\$280*		REMOVAL OF BONE AND/OR SECTIONING OF	
	SURFACES			TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC	\$280*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$55
D6610*	3/MORE SURFACES	\$175*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$85
D0010	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	\$175	D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$125
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/>	\$175*	57210	BONY	Ų 123
	SURFACES		D7241	REMOVAL IMPACTED TOOTH - COMPLETELY	\$150
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL	\$175*		BONY W/SURG COMP	
	2 SURFACES	* /	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS	\$40
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL	\$175*	D7251	(CUTTING PROCEDURE)	\$150
D6614*	3/>SURFACES RETAINER ONLAY - CAST NOBLE METAL 2	\$175*	DIZJI	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	φ130
50011	SURFACES	Ų11 0	D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL	\$175*	D7270	TOOTH REIMPLANTATION AND/OR	\$50
	3/MORE SURFACES			STABILIZATION ACCIDENTLY DISPLACED	
D6624*	RETAINER INLAY - TITANIUM	\$250*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634*	RETAINER ONLAY - TITANIUM	\$250*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$90
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7005	TOOTH TO AID ERUPTION	0.450
D6720*	COMPOSITE PERMANER OF THE PROPERTY OF THE PERMANER OF THE PERM	\$250*	D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D0120	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	φ250	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$60
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$250*	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	\$20
	BASE METAL		D7288	BRUSH BIOPSY	\$20
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$300*	D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	\$40
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7311	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$15
D67F4	HIGH NOBLE METAL		D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$60
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$25
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
	NOBLE METAL	4		(SECONDARY EPITHELIALIZATION)	
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$250*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE	
				ATTACHMENT, REVISION OF SOFT TISSUE	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	00 5
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$30
D7400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$90
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	,
	1.25 CM		D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$85		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$65	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$65	D0006	ENCOUNTER	¢ο
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$65	D9996	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	\$0
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$35		DENTIST FOR SUBSEQUENT REVIEW	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS	\$35	D9999	BROKEN APPOINTMENT	\$20
D7520	COMPLICATED I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
21000	SUBCUTANEOUS	Ψ10	D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$10		ADOLESCENT DENTITION	44.00=
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D8090	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7961	BUCCAL / LABIAL FRENECTOMY	\$45	D8660	ADULT DENTITION	\$250
	(FRENULECTOMY)		D0000	PRE-ORTHODONTIC TREATMENT EXAM TO MONITOR GROWTH AND DEVELOPMENT	ΨΣΟ
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$45	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$45		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$55		OF RETAINERS)	
D7971	EXCISION OF PERICORONAL GINGIVA	\$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	\$100		FOR REASONS OTHER THAN COMPLETION OF	
	TIVE GENERAL SERVICES	210	D8999a	TREATMENT a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10		RECORDS, X-RAYS, TRACING, PHOTOS, AND	,
D9211	REGIONAL BLOCK ANESTHESIA	\$0		MODELS)	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0 \$0			
D9215	LOCAL ANESTHESIA	\$0 \$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
D9222	ANESTHESIA DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
	15 MINUTES	****			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
	15 MINUTE INCREMENT				
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
D0000	NITROUS OXIDE	0440			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
D9243	SEDATION/ANESTHESIA - FIRST 15 MINUTES INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
20210	SEDATION/ANALGESIA - EACH 15 MINUTE	Ψ1.0			
	INCREMENT				
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION,	\$50			
	THIS INCLUDES NON-IV MINIMAL AND				
D0240	MODERATE SEDATION	¢0			
D9310 D9430	CNSLT DX DENT/PHY NOT REQ DENT/PHY OV OBS - NO OTH SERVICES PERFORMED	\$0 \$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	ъэ \$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	φ33 \$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0 \$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$10			
200-10	JUDIO LE GOLLIE L'EDUCCHIELT	ΨιΟ			

'Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

'Copays listed are also applicable in the specialist office.

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

"If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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LIMITATIONS OF BENEFITS

_	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

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

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

- 9. Placement of fixed partial defitures solely for the purpose of achieving periodontal stability.
- 10. 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.
- 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

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:

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

- 1. The following are not Covered orthodontic benefits:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Voluntary 130/covered dental services

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0		DISEASES - SPECIMEN ANALYSIS	
20.00	REPORT	Ψ.	D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT	•	D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5		REPORT	
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	00
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	\$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	MARG PREP/REPORT	\$0
	IMAGE		D0601	CARIES RISK ASSESSMENT AND	Φ0
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	DOCUMENTATION, LOW	\$0
	RADIOGRAPHIC IMAGE		D0002	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	ΨΟ
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0	20000	DOCUMENTATION, HIGH	Ψ0
	IMAGE		D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	, ,
	RADIOGRAPHIC IMAGE		D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE –	\$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0		IMAGE CAPTURE ONLY	
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0		RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0		IMAGE CAPTURE ONLY	
	IMAGES		D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0		IMAGE-IMAGE CAPTURE ONLY	
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	\$0
	ACQUISITION, MEASUREMENT AND ANALYSIS		D0700	IMAGE CAPTURE ONLY	# 0
D0364	CONE BEAM CT CAPTURE AND	\$20	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
	INTERPRETATION WITH LIMITED FIELD OF		D0999	RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY OFFICE VISIT FEE - PER VISIT	\$0
D0365	VIEW-LESS THAN ONE WHOLE JAW	\$20		TIVE SERVICES	ΨΟ
D0303	CONE BEAM CT CAPTURE AND	φ20			40
	INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE		D11101	PROPHYLAXIS - ADULT	\$0
D0366	CONE BEAM CT CAPTURE AND	\$25	D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
20000	INTERPRETATION WITH LIMITED FIELD OF VIEW	4- 0	D11201	6 MONTHS	¢ο
	OF ONE FULL DENTAL ARCH-MAXILLA		D11201	PROPHYLAXIS - CHILD	\$0 *25
D0367	CONE BEAM CT CAPTURE AND	\$25	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	MONTHS TOPICALFLUORIDE VARNISH	\$0
	JAWS				
D0368	CONE BEAM CT CAPTURE AND	\$25	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
	INTERPRETATION FOR TMJ SERIES INCLUDING		D1310	EXCLUDING VARNISH NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
	TWO OR MORE EXPOSURES		D1310	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0 \$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	ORAL HYGIENE INSTRUCTIONS	\$0 \$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0			
	SPECIMEN TO INCLUDE CULTURE AND		D1351	SEALANT - PER TOOTH	\$8
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
D0415	TRANSMISSION OF WRITTEN REPORT COLLECT MICROORGANISMS CULT & SENS	\$0	D1252	CARIES RISK PATIENT- PERM TOOTH	фr
			D1353	SEALANT REPAIR – PER TOOTH	\$5 ¢0
D0416	VIRAL CULTURE	\$10 \$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION – PER TOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$250
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$250
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$250
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$40	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$250
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$40	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$250
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$40	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$250
D1551	RECEM/REBOND BILATERAL SPACE	\$15	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$150
	MAINTAINER – MAXIL	.	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$150
D1552	RECEM/REBOND BILATERAL SPACE	\$15	D0700*	INDIRECT	Φ Ω Γ Ω*
D1553	MAINTAINER – MANDIB RECEM/REBOND UNILATERAL SPACE	\$15	D2720* D2721	CROWN - RESIN WITH HIGH NOBLE METAL CROWN - RESIN W/PREDOM BASE METAL	\$250* \$250*
2.000	MAINTAINER/QUAD	Ψ.0	D2721 D2722*	CROWN - RESIN WITH NOBLE METAL	\$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2722 D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$250 \$300*
	MAINTAINER/QUAD		D2740 D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$250*
D1557	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2750	CROWN - PORCELAIN FUSED PREDOM BASE	\$250*
	MAINTAINER-MAXIL	A	DZIJI	METAL	Ψ230
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$250*
D1575	MAINTAINER-MANDIB	\$25	D2753	CROWN PORCELAIN FUSED TO	\$250
D1070	DISTAL SHOE SPACE MAINTAINER – FIXED, UNILATERAL/QUAD	Ψ23		TITANIUM/TITANIUM ALLOYS	
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$0	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$250*
	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$250*
RESTOR	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$250*
D2140	AMALGAM - ONE SURFACE	\$0	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$250*
	PRIMARY/PERMANENT		D2790*	CROWN - FULL CAST HIGH NOBLE METAL	\$250*
D2150	AMALGAM - TWO SURFACES	\$0	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$250*
D0400	PRIMARY/PERMANENT	Φ0	D2792*	CROWN - FULL CAST NOBLE METAL	\$250*
D2160	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	\$0	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$250*
D2161	AMALGAM - FOUR/MORE SURFACES	\$0	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	\$0
D2330	PRIMARY/PERMANENT RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0	D2915	RECEMENT OR RE-BOND INDIRECTLY	\$0
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0		FABRICATED PREFABRICATED POST & CORE	40
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2920	RECEMENT OR RE-BOND CROWN	\$0
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$40	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$40	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$45	D2931	PRIMARY PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$75	D2001	PERMANENT	Ψ20
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$75	D2932	PREFABRICATED RESIN CROWN	\$40
D2510	INLAY - METALLIC - ONE SURFACE	\$175	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$40
D2520	INLAY - METALLIC - TWO SURFACES	\$175		RESIN WINDOW	
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$175	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$225		STEEL CROWN - PRIMARY	
D2543	ONLAY - METALLIC THREE SURFACES	\$225	D2940	SEDATIVE FILLING	\$0
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$225	D2941	INTERIM THERAPEUTIC RESTORATION –	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$250*	D2950	PRIMARY DENTITION CORE BUILDUP INCLUDING ANY PINS	\$50
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$30 \$10
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$250*	D2951 D2952	POST & CORE ADD CROWN INDIRECT FAB	\$40
	SURFACES		D2952 D2953		\$40 \$40
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	5200	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	Ψ40
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$250*	D2954	PREFABRICATED POST & CORE ADDITION	\$25
		\$250*			· ·

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	RATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962		\$600*		MOLAR	
D2302	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	φουσ	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$50	D3911	INTRAORIFICE BARRIER	\$40
B2011	XST PART DENTURE	ΨΟΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	OONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	\$115
ENDODO	SURFACE LESIONS DNTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$80
		40		TEETH QUAD	,
D3110	PULP CAP - DIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$0		PROC/TOOTH	
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$150
D0004	JUNC	400	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$95
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$30	D4245	APICALLY POSITIONED FLAP	\$165
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$145
			D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$325
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$225
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$40	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	TOOTH ANTERIOR	\$95	D 1200	NATURAL TOOTH – FIRST SITE IN QUADRANT	ΨΠΟ
		·	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3320	BICUSPID	\$175		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3330	MOLAR	\$305		QUADRANT	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$225
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$85	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$85
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$85		TOOTH (WHEN NOT PERFORMED IN	
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$115		CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$175		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$300	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70	D 4070	TOOTH	0.75
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70	D4322	TOOTH	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4022	SPLINT-INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	Ψίδ
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
	MEDICAMENT REPLACEMENT			PROSTHETIC CROWNS	***
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4341	PERIODONTAL SCAL & ROOT PLAN	\$45t
	TREATMENT	**-		4/>TEETH-QUAD	
D3410	APICOECTOMY SURG - ANT	\$95	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$45t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$25
D3425	APICOECTOMY SURG - MOLAR	\$95		MODERATE OR SEVERE GINGIVAL	
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION - FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$50t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900	D4204	ON A SUBSEQUENT VISIT	Φ ΓΓ1
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE	\$55t
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$95		INTO DISEASED CREVICULAR TISSUE, PER TOOTH	
D3/173	PREMOLAR CURRICAL PERAIR OF POOT PECOPITION	\$95	D4910	PERIODONTAL MAINTENANCE	\$30
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	фар	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
	APICOECTOMY OR REPAIR ROOT		REMOV	ABLE PROSTHODONTIC SERVICES	
	RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$275*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$30*
D5120	COMPLETE DENTURE - MANDIBULAR	\$275*		TOOTH	·
D5130	IMMEDIATE DENTURE - MAXILLARY	\$315*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$315*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$250*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$250*	D==40	MANDIBULAR	* 0.5*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$325*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$65*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$325*	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$65*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$115*	D5720	REBASE MAXILLARY PARTIAL DENTURE	\$65*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING	•	D5721	REBASE MANDIBULAR PARTIAL DENTURE	\$65*
	MATERIALS, RESTS AND TEETH)		D5725	REBASE HYBRID PROSTHESIS	\$65
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$115*	D5730	RELINE CMPL MAXIL DENTURE (DIRECT)	\$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE CMPL MAND DENTURE (DIRECT)	\$55*
D=000	MATERIALS, RESTS AND TEETH)	A.1.=	D5740	RELINE MAXIL PART DENTURE (DIRECT)	\$55*
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$115*	D5741	RELINE MAND PART DENTURE (DIRECT)	\$55*
	CAST METAL FRAMEWORK WITH RESIN		D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$75*
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5751	RELINE CMPL MAND DENTURE (INDIRECT)	\$75*
	TEETH)		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$75*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$115*	D5761	RELINE MAND PART DENTURE (INDIRECT)	\$75*
	CAST METAL FRAMEWORK WITH RESIN		D5765	SOFT LINER FOR COMPLETE OR PART	\$20
	DENTURE BASES (INCLUDING		D.F.0.00	REMOVABLE DENTURE-INDIRECT	0445*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$115*
DEOOL	TEETH)	ф 20 г *	D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$115*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$325*	D5850	TISSUE CONDITIONING MAXILLARY	\$20
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$325*	D5851	TISSUE CONDITIONING MANDIBULAR	\$20
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$115	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
D5228	BASE IMMEDIATE MANDIBULAR PARTIAL	\$115	D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
DOZZO	DENTURE-FLEX BASE	ΨΠΟ	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$275*	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
	MAXILLARY		D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$65
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$275*	IMDI AN	DENTURE (PER ARCH) T SERVICES	
	MANDIBULAR				\$975
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$325	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
D=000	FLEX BASE/QUAD	****	D6013	ENDOSTEAL IMPLANT SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
D5286	REMOVABLE UNILATERAL PARTIAL	\$325	D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	DENTURE-RESIN/QUAD	\$10	20000	BAR	Ψοσο
D5410	ADJUST COMPLETE DENTURE - MAXILLARY ADJUST COMPLETE DENTURE - MANDIBULAR	\$10 \$10	D6056	PREFABRICATED ABUTMENT - INCLUDES MOD	\$275
D5411	ADJUST PARTIAL DENTURE - MAXILLARY	\$10 \$10		AND PLACEMENT	
D5421	ADJUST PARTIAL DENTURE - MANDIBULAR	\$10	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422				PLACEMENT	
	REPAIR BROKEN COMPLETE DENTURE BASE	\$30*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$30*	D00=0+	CROWN	A0=0
D5520	MAXILLARY REPLACE MISSING/BROKEN TEETH - COMPLETE	\$30*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D0020	DENTURE	φοσ	D6060	METAL CROWN (HIGH NOBLE METAL)	\$610
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$30*	D0000	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	φοιο
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$30*	2000.	METAL CROWN (NOBLE METAL)	Ų 000
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$30*		(HIGH NOBLE METAL)	
D=005	MANDIBULAR	***	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$30*		(PREDOMINATELY BASE METAL)	
DEESO	MAXILLARY	¢ኃቦ*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	\$30*	Dooos	(NOBLE METAL)	***
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$30*	D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC	\$690
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$30*		CROWN	
_ 5556		ΨΟΟ			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)		20.02	DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	ΨΞ. ΰ
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH –	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	,,,,
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40		TO TITANIUM/TITANIUM ALLOYS	****
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	φοσο
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	*****	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	,
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$250*
20000	ALLOYS	ψοιο	D6211	PONTIC - CAST PREDOM BASE METAL	\$250*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$250*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$250*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$250*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$250*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$250*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$250*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$300*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$250*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED PI	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$250*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$250*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	DC700*	BASE METAL	ФОГО*
D0540	PROSTHESIS	*200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$250*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC RETAINER CROWN - 3/4 TITANIUM/TITANIUM	\$300* \$250*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	ALLOYS RETAINER CROWN - 5/4 THANIOW/THANIOW/ ALLOYS	\$250*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$270*		METAL	
D6601	SURFACES	\$270*	D6791	RETAINER CROWN - FULL CAST	\$250*
D0001	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	Ψ210	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$250*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	\$175*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	\$250*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$175*	D6920	CONNECTOR BAR	\$85
Decov	SURFACES	¢175*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL	\$0
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	\$175*	D6940	DENTURE STRESS BREAKER	\$125
D6605	RETAINER INLAY - CAST PREDOM BASE METAL	\$175*	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$125 \$60
	3/>SURFACES			JRGERY SERVICES	ΨΟΟ
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$175*	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$8
D6607*	SURFACES RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$175*	D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$8
2000.	SURFACES	4	D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$30
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$280*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$280*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$55
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2	\$175*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$85
D6611*	SURFACES	\$175*	D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	\$125
	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES		D7241	REMOVAL IMPACTED TOOTH - COMPLETELY	\$150
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	\$175*	D7250	BONY W/SURG COMP REMOVAL OF RESIDUAL TOOTH ROOTS	\$40
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$175*	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$175*		REMOVAL	
	SURFACES	.	D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	\$175*	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$50
D6624*	RETAINER INLAY - TITANIUM	\$250*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634*	RETAINER ONLAY - TITANIUM	\$250*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$90
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	\$185*	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE	\$250*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$60
	METAL		D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$250*		COLLECTION	
D6722*	BASE METAL RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$300*	D7290 D7310	SURGICAL REPOSITIONING OF TEETH	\$75 \$40
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$40 \$15
	HIGH NOBLE METAL		D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$60
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$25
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
	NOBLE METAL		רבטרי	(SECONDARY EPITHELIALIZATION)	<u> </u>
D6753	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$250*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	\$670

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	00 5
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$30
D7400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$90
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	,
	1.25 CM		D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$85		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$65	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$65	Doooe	ENCOUNTER	¢ο
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$65	D9996	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	\$0
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$35		DENTIST FOR SUBSEQUENT REVIEW	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS	\$35	D9999	BROKEN APPOINTMENT	\$20
D7520	COMPLICATED I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
21000	SUBCUTANEOUS	Ψ10	D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$10		ADOLESCENT DENTITION	44.00=
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D8090	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7961	BUCCAL / LABIAL FRENECTOMY	\$45	D8660	ADULT DENTITION	\$250
	(FRENULECTOMY)		D0000	PRE-ORTHODONTIC TREATMENT EXAM TO MONITOR GROWTH AND DEVELOPMENT	ΨΣΟ
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$45	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$45		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$55		OF RETAINERS)	
D7971	EXCISION OF PERICORONAL GINGIVA	\$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	\$100		FOR REASONS OTHER THAN COMPLETION OF	
	TIVE GENERAL SERVICES	A 40	D8999a	TREATMENT a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10		RECORDS, X-RAYS, TRACING, PHOTOS, AND	,
D9211	REGIONAL BLOCK ANESTHESIA	\$0		MODELS)	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0 \$0			
D9215	LOCAL ANESTHESIA	\$0 \$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
D9222	ANESTHESIA DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
	15 MINUTES	****			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
	15 MINUTE INCREMENT				
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
D0000	NITROUS OXIDE	0440			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
D9243	SEDATION/ANESTHESIA - FIRST 15 MINUTES INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
20210	SEDATION/ANALGESIA - EACH 15 MINUTE	Ψ1.0			
	INCREMENT				
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION,	\$50			
	THIS INCLUDES NON-IV MINIMAL AND				
D0340	MODERATE SEDATION CNSLT DY DENT/DHY NOT BEG DENT/DHY	ሱ ስ			
D9310 D9430	CNSLT DX DENT/PHY NOT REQ DENT/PHY OV OBS - NO OTH SERVICES PERFORMED	\$0 \$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	ъэ \$35			
D9440 D9450	CASE PRSATION DTL & EXT TX PLANNING	ъзэ \$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0 \$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$10			
200-10	JUDIONIE GONINE / NEGOTINE (1)	ΨιΟ			

¹Additional Prophy within 6 months will be based upon the necessity recommended by the provider. ²Copays listed are also applicable in the specialist office. For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service. *If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

UnitedHealthcare/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 Benefit

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		• Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

10

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

- any country.
- 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 Dental Services or Procedures not listed in the Schedule of Covered Dental Services. 11.
- Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 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.
- 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.
- Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 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.

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:

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

- 1. The following are not Covered orthodontic benefits:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Contributory 130C/covered dental services

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0		DISEASES - SPECIMEN ANALYSIS	
	REPORT	•	D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0470	REPORT	40
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	\$0
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	φυ
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	CARIES RISK ASSESSMENT AND	\$0
	IMAGE		2000.	DOCUMENTATION, LOW	***
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
D0040	RADIOGRAPHIC IMAGE	00		DOCUMENTATION, MODERATE	
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
D0251	IMAGE	\$0	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0231	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	ΨΟ		CAPTURE ONLY	
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	IMAGE CAPTURE ONLY	Φ0.
D0272	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	\$0
D0277		\$0	D0700	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE- IMAGE CAPTURE ONLY	ΨΟ
DOZII	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	ΨΟ	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0		IMAGE-IMAGE CAPTURE ONLY	,,
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	\$0
	ACQUISITION, MEASUREMENT AND ANALYSIS			IMAGE CAPTURE ONLY	
D0364	CONE BEAM CT CAPTURE AND	\$20	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
	INTERPRETATION WITH LIMITED FIELD OF			RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	
	VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$5
D0365	CONE BEAM CT CAPTURE AND	\$20	PREVEN	ITIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D1110 ¹	PROPHYLAXIS - ADULT	\$0
Dusee	OF ONE FULL DENTAL ARCH-MANDIBLE	\$25	D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW	φ25		6 MONTHS	
	OF ONE FULL DENTAL ARCH-MAXILLA		D11201	PROPHYLAXIS - CHILD	\$0
D0367	CONE BEAM CT CAPTURE AND	\$25	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	MONTHS TODICAL FLUORIDE MARNISH	¢0
	JAWS		D1206	TOPICALFLUORIDE VARNISH	\$0
D0368	CONE BEAM CT CAPTURE AND	\$25	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
	INTERPRETATION FOR TMJ SERIES INCLUDING		D1310	EXCLUDING VARNISH NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0004	TWO OR MORE EXPOSURES	^ -	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0	D1351	SEALANT - PER TOOTH	\$8
	SPECIMEN TO INCLUDE CULTURE AND		D1351		\$10
	SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT		D 1002	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	φΙΟ
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10	000	APPLICATION – PER TOOTH	40
		Ψι		20	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$250
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$250
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$250
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$40	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$250
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$40	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$250
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$40	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$250
D1551	RECEM/REBOND BILATERAL SPACE	\$15	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$150
D.1==0	MAINTAINER – MAXIL	A 4 =	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$150
D1552	RECEM/REBOND BILATERAL SPACE	\$15	D0700*	INDIRECT	ФОГО*
D1553	MAINTAINER – MANDIB RECEM/REBOND UNILATERAL SPACE	\$15	D2720* D2721	CROWN - RESIN WITH HIGH NOBLE METAL CROWN - RESIN W/PREDOM BASE METAL	\$250* \$250*
	MAINTAINER/QUAD	***	D2721 D2722*	CROWN - RESIN WITH NOBLE METAL	\$250*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$15	D2722	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$300*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$250*
D1557	REMOVAL OF FIXED BILATERAL SPACE	\$15	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$250*
D1EE0	MAINTAINER-MAXIL	\$15	22.0.	METAL	4 200
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	\$10	D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$250*
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED.	\$25	D2753	CROWN PORCELAIN FUSED TO	\$250
	UNILATERAL/QUAD			TITANIUM/TITANIUM ALLOYS	
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$5	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$250*
	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$250*
	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$250*
D2140	AMALGAM - ONE SURFACE	\$0	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$250*
D2150	PRIMARY/PERMANENT	\$0	D2790*	CROWN - FULL CAST PREDOM PASE METAL	\$250*
DZ 130	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	ΨΟ	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$250*
D2160	AMALGAM - 3 SURFACES	\$0	D2792* D2794*	CROWN - FULL CAST NOBLE METAL CROWN - TITANIUM AND TITANIUM ALLOYS	\$250* \$250*
	PRIMARY/PERMAMENT		D2794 D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$250 \$0
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	\$0		OR PART COV REST	,
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0	D2915	RECEMENT OR RE-BOND INDIRECTLY	\$0
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0	D2020	FABRICATED PREFABRICATED POST & CORE RECEMENT OR RE-BOND CROWN	¢ 0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2920 D2921		\$0 \$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2921 D2929	REATTACHMENT OF TOOTH FRAGMENT PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$40	D2929 D2930		\$25
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$40	D2330	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	ΨΖΟ
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$45	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$75		PERMANENT	
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$75	D2932	PREFABRICATED RESIN CROWN	\$40
D2510	INLAY - METALLIC - ONE SURFACE	\$175	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$40
D2520	INLAY - METALLIC - TWO SURFACES	\$175	D0004	RESIN WINDOW	400
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$175	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$225	D2940	STEEL CROWN - PRIMARY SEDATIVE FILLING	\$0
D2543	ONLAY - METALLIC THREE SURFACES	\$225	D2941	INTERIM THERAPEUTIC RESTORATION –	\$5
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$225	220	PRIMARY DENTITION	40
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$250*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$50
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$10
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$250*	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$40
D2642	SURFACES ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$250*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$40
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$250*		ТООТН	
52070	ONE IT TOROLLY MINOLIVANIO - 3 SUNTACES	\$250*	D2954	PREFABRICATED POST & CORE ADDITION	\$25

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	RATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962		\$600*		MOLAR	
D2302	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	φουσ	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$50	D3911	INTRAORIFICE BARRIER	\$40
B2011	XST PART DENTURE	ΨΟΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	OONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	\$115
ENDODO	SURFACE LESIONS DNTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$80
		40		TEETH QUAD	,
D3110	PULP CAP - DIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$0		PROC/TOOTH	
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$150
D0004	JUNC	400	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$95
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$30	D4245	APICALLY POSITIONED FLAP	\$165
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$145
			D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$325
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$40	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$225
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$40	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	TOOTH ANTERIOR	\$95	D 1200	NATURAL TOOTH – FIRST SITE IN QUADRANT	ΨΠΟ
		·	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$90
D3320	BICUSPID	\$175		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3330	MOLAR	\$305		QUADRANT	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$225
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$85	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$85
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$85		TOOTH (WHEN NOT PERFORMED IN	
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$115		CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$175		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$300	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$70	D 4070	TOOTH	0.75
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$70	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$70	D4322	TOOTH	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4022	SPLINT-INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	Ψίδ
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
	MEDICAMENT REPLACEMENT			PROSTHETIC CROWNS	***
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4341	PERIODONTAL SCAL & ROOT PLAN	\$45t
	TREATMENT	**-		4/>TEETH-QUAD	
D3410	APICOECTOMY SURG - ANT	\$95	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$45t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$25
D3425	APICOECTOMY SURG - MOLAR	\$95		MODERATE OR SEVERE GINGIVAL	
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION - FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$50t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900	D4204	ON A SUBSEQUENT VISIT	Φ ΓΓ1
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE	\$55t
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$95		INTO DISEASED CREVICULAR TISSUE, PER TOOTH	
D3/173	PREMOLAR CURRICAL PERAIR OF POOT PECOPITION	\$95	D4910	PERIODONTAL MAINTENANCE	\$30
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	фар	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
	APICOECTOMY OR REPAIR ROOT		REMOV	ABLE PROSTHODONTIC SERVICES	
	RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$275*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$30*
D5120	COMPLETE DENTURE - MANDIBULAR	\$275*		TOOTH	·
D5130	IMMEDIATE DENTURE - MAXILLARY	\$315*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$315*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$250*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$250*	D==40	MANDIBULAR	* 0.5*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$325*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$65*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$325*	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$65*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$115*	D5720	REBASE MAXILLARY PARTIAL DENTURE	\$65*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING	•	D5721	REBASE MANDIBULAR PARTIAL DENTURE	\$65*
	MATERIALS, RESTS AND TEETH)		D5725	REBASE HYBRID PROSTHESIS	\$65
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$115*	D5730	RELINE CMPL MAXIL DENTURE (DIRECT)	\$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE CMPL MAND DENTURE (DIRECT)	\$55*
D=000	MATERIALS, RESTS AND TEETH)	A.1.=	D5740	RELINE MAXIL PART DENTURE (DIRECT)	\$55*
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$115*	D5741	RELINE MAND PART DENTURE (DIRECT)	\$55*
	CAST METAL FRAMEWORK WITH RESIN		D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$75*
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5751	RELINE CMPL MAND DENTURE (INDIRECT)	\$75*
	TEETH)		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$75*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$115*	D5761	RELINE MAND PART DENTURE (INDIRECT)	\$75*
	CAST METAL FRAMEWORK WITH RESIN		D5765	SOFT LINER FOR COMPLETE OR PART	\$20
	DENTURE BASES (INCLUDING		D.F.0.00	REMOVABLE DENTURE-INDIRECT	0445*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$115*
DEOOL	TEETH)	ф 20 г *	D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$115*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$325*	D5850	TISSUE CONDITIONING MAXILLARY	\$20
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$325*	D5851	TISSUE CONDITIONING MANDIBULAR	\$20
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$115	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
D5228	BASE IMMEDIATE MANDIBULAR PARTIAL	\$115	D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
DOZZO	DENTURE-FLEX BASE	ΨΠΟ	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$275*	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
	MAXILLARY		D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$65
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$275*	IMDI AN	DENTURE (PER ARCH) T SERVICES	
	MANDIBULAR				\$975
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$325	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
D=000	FLEX BASE/QUAD	****	D6013	ENDOSTEAL IMPLANT SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
D5286	REMOVABLE UNILATERAL PARTIAL	\$325	D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	DENTURE-RESIN/QUAD	\$10	20000	BAR	Ψοσο
D5410	ADJUST COMPLETE DENTURE - MAXILLARY ADJUST COMPLETE DENTURE - MANDIBULAR	\$10 \$10	D6056	PREFABRICATED ABUTMENT - INCLUDES MOD	\$275
D5411	ADJUST PARTIAL DENTURE - MAXILLARY	\$10 \$10		AND PLACEMENT	
D5421	ADJUST PARTIAL DENTURE - MANDIBULAR	\$10	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422				PLACEMENT	
	REPAIR BROKEN COMPLETE DENTURE BASE	\$30* \$30*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$30*	D00=0+	CROWN	A0=0
D5520	MAXILLARY REPLACE MISSING/BROKEN TEETH - COMPLETE	\$30*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D0020	DENTURE	φοσ	D6060	METAL CROWN (HIGH NOBLE METAL)	\$610
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$30*	D0000	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	φοιο
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$30*	2000.	METAL CROWN (NOBLE METAL)	Ų 000
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$30*		(HIGH NOBLE METAL)	
D=005	MANDIBULAR	***	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$30*		(PREDOMINATELY BASE METAL)	
DEESO	MAXILLARY	¢ኃቦ*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	\$30*	Dooos	(NOBLE METAL)	***
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$30*	D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC	\$690
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$30*		CROWN	
_ 5556		ΨΟΟ			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)		20.02	DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	ΨΞ. ΰ
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH –	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	,,,,
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40		TO TITANIUM/TITANIUM ALLOYS	****
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	φοσο
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	*****	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	,
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$250*
20000	ALLOYS	ψοιο	D6211	PONTIC - CAST PREDOM BASE METAL	\$250*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$250*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$250*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$250*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$250*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$250*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$250*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$300*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$250*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$250*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$250*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED PI	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$250*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$250*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	D0700*	BASE METAL	\$050 *
D6E49	PROSTHESIS	¢200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$250* \$200*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$300* \$250*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$270*		RETAINER CROWN - FULL CAST HIGH NOBLE METAL	\$250*
D6601	SURFACES DETAINED INLAY DODGELAIN/CERAMIC	\$270*	D6791	RETAINER CROWN - FULL CAST	\$250*
D0001	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	Ψ210	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$250*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	\$175*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	\$250*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$175*	D6920	CONNECTOR BAR	\$85
DCCOA	SURFACES	0475*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL	\$0
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	\$175*	DC040	DENTURE	6405
D6605	RETAINER INLAY - CAST PREDOM BASE METAL	\$175*	D6940 D6980	STRESS BREAKER FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$125 \$60
	3/>SURFACES			URGERY SERVICES	φ00
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$175*	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$8
D6607*	SURFACES RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$175*	D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$8
20001	SURFACES	V110	D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$30
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$280*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$280*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$55
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2	\$175*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$85
D6611*	SURFACES	\$175*	D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	\$125
	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES		D7241	REMOVAL IMPACTED TOOTH - COMPLETELY	\$150
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	\$175*	D7250	BONY W/SURG COMP REMOVAL OF RESIDUAL TOOTH ROOTS	\$40
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$175*	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$175*		REMOVAL	****
	SURFACES		D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	\$175*	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$50
D6624*	RETAINER INLAY - TITANIUM	\$250*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634*	RETAINER ONLAY - TITANIUM	\$250*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$90
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150
D6720*	COMPOSITE RETAINER CROWN - RESIN WITH HIGH NOBLE	\$250*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$150 \$60
	METAL METAL	¥-53	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$250*		COLLECTION	
D6722*	BASE METAL RETAINER CROWN - RESIN WITH NOBLE METAL	\$250*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$300*	D7290 D7310	SURGICAL REPOSITIONING OF TEETH	\$75 \$40
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$40 \$15
	HIGH NOBLE METAL		D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$60
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$25
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$250*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
	NOBLE METAL	4-00	D70-0	(SECONDARY EPITHELIALIZATION)	*^
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$250*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	00 5
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$30
D7400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$90
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	,
	1.25 CM		D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$85		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$65	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$65	Doooe	ENCOUNTER	¢ο
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$65	D9996	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	\$0
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$35		DENTIST FOR SUBSEQUENT REVIEW	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS	\$35	D9999	BROKEN APPOINTMENT	\$20
D7520	COMPLICATED I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
21000	SUBCUTANEOUS	Ψ10	D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$10		ADOLESCENT DENTITION	44.00=
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$25	D8090	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7961	BUCCAL / LABIAL FRENECTOMY	\$45	D8660	ADULT DENTITION	\$250
	(FRENULECTOMY)		D0000	PRE-ORTHODONTIC TREATMENT EXAM TO MONITOR GROWTH AND DEVELOPMENT	ΨΣΟ
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$45	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$45		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$55		OF RETAINERS)	
D7971	EXCISION OF PERICORONAL GINGIVA	\$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	\$100		FOR REASONS OTHER THAN COMPLETION OF	
	TIVE GENERAL SERVICES	A 40	D8999a	TREATMENT a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$10		RECORDS, X-RAYS, TRACING, PHOTOS, AND	,
D9211	REGIONAL BLOCK ANESTHESIA	\$0		MODELS)	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0 \$0			
D9215	LOCAL ANESTHESIA	\$0 \$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
D9222	ANESTHESIA DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
	15 MINUTES	****			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
	15 MINUTE INCREMENT				
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
D0000	NITROUS OXIDE	0440			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
D9243	SEDATION/ANESTHESIA - FIRST 15 MINUTES INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
20210	SEDATION/ANALGESIA - EACH 15 MINUTE	Ψ1.0			
	INCREMENT				
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION,	\$50			
	THIS INCLUDES NON-IV MINIMAL AND				
D0340	MODERATE SEDATION CNSLT DY DENT/DHY NOT BEG DENT/DHY	ሱ ስ			
D9310 D9430	CNSLT DX DENT/PHY NOT REQ DENT/PHY OV OBS - NO OTH SERVICES PERFORMED	\$0 \$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	ъэ \$35			
D9440 D9450	CASE PRSATION DTL & EXT TX PLANNING	ъзэ \$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0 \$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$10			
200-10	JUDIONIE GONINE / NEGOTINE (1)	ΨιΟ			

'Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

2Copays listed are also applicable in the specialist office.

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

*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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This plan is underwritten by National Pacific Dental, Inc.

UnitedHealthcare/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 Benefit

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		• Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

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

ben	Deficit on this Flan'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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.					
6.	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.					
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.					

- 8. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- 8. Procedures related to the reconstruction of a patient's correct vertical differsion of occusion (VDO)
- 9. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 10. 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.
- 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

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:

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

- 1. The following are not Covered orthodontic benefits:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Contributory 140/covered dental services

TX D093N

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0405	DISEASES - SPECIMEN ANALYSIS	40
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0470	REPORT	*
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	\$0
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	ΦΟ
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	MARG PREP/REPORT CARIES RISK ASSESSMENT AND	\$0
	IMAGE		D0001	DOCUMENTATION, LOW	Ψ
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
	RADIOGRAPHIC IMAGE			DOCUMENTATION, MODERATE	**
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
D0054	IMAGE	Φ0	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	
D0270	RADIOGRAPHIC IMAGE BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0
		•		IMAGE CAPTURE ONLY	
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0		RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0	D0707	IMAGE CAPTURE ONLY	*
D0000	IMAGES	Φ0	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0	D0708	IMAGE-IMAGE CAPTURE ONLY	\$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0706	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	ΦΟ
D0364	ACQUISITION, MEASUREMENT AND ANALYSIS	\$15	D0709	IMAGE CAPTURE ONLY INTRAORAL-COMPLETE SERIES OF	\$0
D0304	CONE BEAM CT CAPTURE AND	\$10	20.00	RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	Ų.
	INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$0
D0365	CONE BEAM CT CAPTURE AND	\$15	PREVEN	ITIVE SERVICES	, ,
20000	INTERPRETATION WITH LIMITED FIELD OF VIEW	4.0	D1110 ¹	PROPHYLAXIS - ADULT	\$0
	OF ONE FULL DENTAL ARCH-MANDIBLE		D1110 ¹		\$25
D0366	CONE BEAM CT CAPTURE AND	\$20	DIIIO	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	ΨΖϽ
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11201	PROPHYLAXIS - CHILD	\$0
	OF ONE FULL DENTAL ARCH-MAXILLA		D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
D0367	CONE BEAM CT CAPTURE AND	\$20	51120	MONTHS	Ψ20
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	TOPICALFLUORIDE VARNISH	\$0
	JAWS		D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
D0368	CONE BEAM CT CAPTURE AND	\$20		EXCLUDING VARNISH	**
	INTERPRETATION FOR TMJ SERIES INCLUDING		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	TWO OR MORE EXPOSURES INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
		\$0 \$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	Φ0	D1351	SEALANT - PER TOOTH	\$5
	SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
	TRANSMISSION OF WRITTEN REPORT		D 1002	CARIES RISK PATIENT- PERM TOOTH	ΨΙΟ
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
		Ţ.5	_ 1000	ORINIEO I INEVERVITVE MILDIOMMENT	ΨΟ

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$175
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$175
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$175
D1520	SPACE MAINTAINER -	\$35	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$175
D1526	REMOVABLE-UNILATERAL/QUAD SPACE MAINTAINER - REMOVABLE - BILATERAL,	\$35	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$175
D1527	MAXILLARY SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$35	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$175
D1551	RECEM/REBOND BILATERAL SPACE	\$5	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$125
D1552	MAINTAINER – MAXIL	\$5	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$125
D 1002	RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB	ΨΟ	D2720*	INDIRECT CROWN - RESIN WITH HIGH NOBLE METAL	\$175*
D1553	RECEM/REBOND UNILATERAL SPACE	\$5	D2721	CROWN - RESIN W/PREDOM BASE METAL	\$175*
	MAINTAINER/QUAD		D2722*	CROWN - RESIN WITH NOBLE METAL	\$175*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$10	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$225*
D4557	MAINTAINER/QUAD	040	D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$175*
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$10	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$175*
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$10	D2752*	METAL CROWN - PORCELAIN FUSED NOBLE METAL	\$175*
D1575	MAINTAINER-MANDIB DISTAL SHOE SPACE MAINTAINER – FIXED,	\$25	D2753	CROWN PORCELAIN FUSED TO	\$175
	UNILATERAL/QUAD		D.0=0.0±	TITANIUM/TITANIUM ALLOYS	A 4 = 5 +
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$0	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$175*
DESTOR	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$175*
	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$175*
D2140	AMALGAM - ONE SURFACE	\$0	D2783 D2790*	CROWN - 3/4 PORCELAIN/CERAMIC CROWN - FULL CAST HIGH NOBLE METAL	\$175* \$175*
D2150	PRIMARY/PERMANENT AMALGAM - TWO SURFACES	\$0	D2790 D2791	CROWN - FULL CAST PREDOM BASE METAL	\$175 \$175*
B2100	PRIMARY/PERMANENT	Ψ	D2791*	CROWN - FULL CAST NOBLE METAL	\$175*
D2160	AMALGAM - 3 SURFACES	\$0	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$175*
D2161	PRIMARY/PERMAMENT AMALGAM - FOUR/MORE SURFACES	\$0	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$0
	PRIMARY/PERMANENT	·	D2915	OR PART COV REST RECEMENT OR RE-BOND INDIRECTLY	\$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0		FABRICATED PREFABRICATED POST & CORE	**
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0	D2920	RECEMENT OR RE-BOND CROWN	\$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$25	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2391 D2392	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$30 \$40	D0004	PRIMARY	*0-
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$40 \$55	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2393	RESIN COMPOSITE - 4/MORE SURFACES POST	\$55 \$55	D2932	PERMANENT PREFABRICATED RESIN CROWN	\$35
D2534	INLAY - METALLIC - ONE SURFACE	\$150	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$35
D2520	INLAY - METALLIC - TWO SURFACES	\$150		RESIN WINDOW	***
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$150	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$150		STEEL CROWN - PRIMARY	
D2543	ONLAY - METALLIC THREE SURFACES	\$150	D2940	SEDATIVE FILLING	\$0
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$150	D2941	INTERIM THERAPEUTIC RESTORATION -	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$175*	D2950	PRIMARY DENTITION CORE BUILDUP INCLUDING ANY PINS	\$25
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$175*	D2950 D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$25 \$10
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$175*	D2951 D2952	POST & CORE ADD CROWN INDIRECT FAB	\$35
	SURFACES		D2952 D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$35 \$25
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$175*	52000	TOOTH	Ψ23
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$175*	D2954	PREFABRICATED POST & CORE ADDITION	\$20
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$175*		CROWN	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962	LABIAL VENEER (PORCELAIN LAMINATE) -	\$600*	D2040	MOLAR	Ф4 Г
	INDIRECT	, , , ,	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$35	D3911	INTRAORIFICE BARRIER	\$30
	XST PART DENTURE		D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST CONTIC SERVICES	\$15
D2980	CROWN REPAIR	\$35			6445
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$115
	SURFACE LESIONS		D4211	TEETH QUAD	\$75
	ONTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	ΨΙΟ
D3110	PULP CAP - DIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$0		PROC/TOOTH	***
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$140
D0004	JUNC	0.4 F	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$85
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$15	D4245	APICALLY POSITIONED FLAP	\$165
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$115
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$25	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$325
D3240		\$25 \$25	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$215
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	ΨΖϽ	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	ANTERIOR	\$75		NATURAL TOOTH - FIRST SITE IN QUADRANT	
D3320	BICUSPID	\$150	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$75
D3330	MOLAR	\$275		NATURAL TOOTH - EACH ADDITIONAL SITE IN	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D 10=0	QUADRANT	***
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$65	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$215
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$65	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$65
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$100		TOOTH (WHEN NOT PERFORMED IN	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$170		CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$295	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$65		TOOTH	
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$65	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$65		ТООТН	
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	\$75
D3356		\$65		PROSTHETIC CROWNS	
D3330	PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT	ΨΟΟ	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4244	PROSTHETIC CROWNS	¢40+
	TREATMENT		D4341	PERIODONTAL SCAL & ROOT PLAN	\$40t
D3410	APICOECTOMY SURG - ANT	\$95	D4342	4/>TEETH-QUAD PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$28t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$25
D3425	APICOECTOMY SURG - MOLAR	\$95	Бчочо	MODERATE OR SEVERE GINGIVAL	Ψ20
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION – FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$40t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900		ON A SUBSEQUENT VISIT	
D3471	SURGICAL REPAIR OF ROOT RESORPTION -	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL	\$35t
	ANTERIOR			AGENTS VIA A CONTROLLED RELEASE VEHICLE	
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$95		INTO DISEASED CREVICULAR TISSUE, PER	
	PREMOLAR		D4910	TOOTH PERIODONTAL MAINTENANCE	\$30
D3473	SURGICAL REPAIR OF ROOT RESORPTION -	\$95	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D2504	MOLAR	* 050	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250		ABLE PROSTHODONTIC SERVICES	40
	APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$225*
	NEOONI I-MITENION		20110	JOIN EELE DEITIONE INVOICEMENT	ΨΖΖΟ

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$25*
D5120	COMPLETE DENTURE - MANDIBULAR	\$225*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$250*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$250*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$275*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$275*	DE740	MANDIBULAR	ФГ Г*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$275*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$55* \$55*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$275*	D5711 D5720	REBASE COMPLETE MANDIBULAR DENTURE	\$55*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$55*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$55* \$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$55 \$55
	MATERIALS, RESTS AND TEETH)		D5725	RELINE CMPL MAXIL DENTURE (DIRECT)	φ35*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$55*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$35*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$35*
D5223	MATERIALS, RESTS AND TEETH)	\$55*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$35*
D0220	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ΨΟΟ	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$55*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$55*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$55*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$55*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$55*	D5765	SOFT LINER FOR COMPLETE OR PART	\$10
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	Ψισ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$55*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$55*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$350*	D5850	TISSUE CONDITIONING MAXILLARY	\$10
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$350*	D5851	TISSUE CONDITIONING MANDIBULAR	\$10
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$55	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$55	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE	****	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$260*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$55
D5283	MAXILLARY REMOVABLE UNILATERAL PARTIAL DENTURE -	\$260*		DENTURE (PER ARCH)	
D0200	MANDIBULAR	Ψ200	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$350	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	****
D5286	REMOVABLE UNILATERAL PARTIAL	\$350	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$0	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$0	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖΙΟ
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$0	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$0		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$25*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$25*		CROWN	
D5520	MAXILLARY PERI ACE MISSING/PROVEN TEETLY COMPLETE	\$25*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	ΨΣΟ	Denen	METAL CROWN (HIGH NOBLE METAL)	¢640
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$25*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$25*		METAL CROWN (NOBLE METAL)	7
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$25*		(HIGH NOBLE METAL)	
DEGOO	MANDIBULAR	<u></u>	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$25*	D0004	(PREDOMINATELY BASE METAL)	4-4-
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$25*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
_ 5550	TOOTH	Ψ - -	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$25*	20000	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	ψυσυ
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$25*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	·	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)			DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	,
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	*	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH -	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυθυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	****	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	·
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40	D0404	TO TITANIUM/TITANIUM ALLOYS	***
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	φοσο
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	,	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	****		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$125*
D0000	ALLOYS	ψοιο	D6211	PONTIC - CAST PREDOM BASE METAL	\$125*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$125*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$125*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$125*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$125*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT		D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$125*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$125*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	D 00 :=	TITANIUM/TITANIUM ALLOYS	A
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨίΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$215*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$125*
	AND TITANIUM ALLOYS	•	D6251	PONTIC RESIN W/PREDOM BASE METAL	\$125*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$125*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED PI	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$125*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$125*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	D0700*	BASE METAL	\$405 *
DCE 40	PROSTHESIS	#200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$125* \$175*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC RETAINER CROWN - 3/4 TITANIUM/TITANIUM	\$175* \$125*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	ALLOYS RETAINER CROWN - 5/4 THANIOM/THANIOM/ ALLOYS	\$125*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$145*		METAL	
DCC04	SURFACES	Φ4.4 . F.*	D6791	RETAINER CROWN - FULL CAST	\$125*
D6601	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$145*	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$125*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2	\$115*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$125*
	SURFACES	***		ALLOYS	
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	\$115*	D6920	CONNECTOR BAR	\$85
D6604	RETAINER INLAY - CAST PREDOM BASE METAL	\$115*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	\$0
	2 SURFACES		D6940	STRESS BREAKER	\$110
D6605	RETAINER INLAY - CAST PREDOM BASE METAL	\$115*	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$60
D6606*	3/>SURFACES RETAINER INLAY - CAST NOBLE METAL 2	\$115*	ORAL SI	JRGERY SERVICES	
D0000	SURFACES	φHJ	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$0
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$115*	D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$0
	SURFACES		D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$15
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$155*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$155*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$25
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2	\$115*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$50
	SURFACES		D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$75
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$115*	D7241	BONY DEMOVAL IMPACTED TOOTH, COMPLETELY	\$90
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL	\$150*	D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	ψου
D0040	2 SURFACES	*450*	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS	\$0
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$150*	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$115*		REMOVAL	****
	SURFACES		D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL	\$115*	D7270	TOOTH REIMPLANTATION AND/OR	\$50
D6624*	3/MORE SURFACES RETAINER INLAY - TITANIUM	\$125*	D7000	STABILIZATION ACCIDENTLY DISPLACED	Ф05
D6634*	RETAINER INLAY - TITANIUM	\$125*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	\$85
	COMPOSITE	****	D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$0
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE	\$125*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$0
	METAL	***	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$125*		COLLECTION	
D6722*	BASE METAL RETAINER CROWN - RESIN WITH NOBLE METAL	\$125*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$215*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7310 D7311	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$0 \$0
	HIGH NOBLE METAL		D7311	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$0 \$0
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$0
D6752*	PREDOMINANTLY BASE METAL	\$125*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
שנוטע	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	\$120		(SECONDARY EPITHELIALIZATION)	
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$125*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS	, .		(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM	•	D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110		ARCH	
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
	1.25 CM		D0054	ARCH	40
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$100	D9951	OCCLUSAL ADJUSTMENT - LIMITED	\$0
D7461	OR TUMOR - LESION DIAMETER UP TO 1.25 CM	¢125	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$0 \$105
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	1.25 CM		D9975	PERFORMED IN OFFICE	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$75	D3313	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	ψ123
D7472	REMOVAL OF TORUS PALATINUS	\$25	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$25		ENCOUNTER	
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$25	D9996	TELEDENTISTRY - ASYNCHRONOUS;	\$0
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$15		INFORMATION STORED AND FORWARDED TO	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS	\$15		DENTIST FOR SUBSEQUENT REVIEW	
	COMPLICATED	, -	D9999	BROKEN APPOINTMENT	\$10
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	* 4.00=
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$0	D8090	ADOLESCENT DENTITION	\$1,895
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$15	D0090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	φ1,095
D7961	BUCCAL / LABIAL FRENECTOMY	\$0	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
	(FRENULECTOMY)			MONITOR GROWTH AND DEVELOPMENT	¥-55
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$0	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$0		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$25		OF RETAINERS)	
D7971	EXCISION OF PERICORONAL GINGIVA	\$20	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	\$40		RECORDS, X-RAYS,TRACING, PHOTOS, AND	
ADJUNC	TIVE GENERAL SERVICES			MODELS)	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$5			
D9211	REGIONAL BLOCK ANESTHESIA	\$0			
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0			
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	\$0			
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	\$150			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	\$75			
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	\$30			
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	\$140			
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	\$70			
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	\$50			
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$0			

'Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

2 Copays listed are also applicable in the specialist office.

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

1 If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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This plan is underwritten by National Pacific Dental, Inc.

UnitedHealthcare/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 Benefit

1.	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
2.	COMPLETE SERIES OR PANOREX	Limited to 1 time in any 2 year period
	RADIOGRAPHS	
3.	BITEWING RADIOGRAPHS	Limited to 1 series of 4 films in any 6 month period
4.	DENTAL PROPHYLAXIS	Limited to 1 time per 6 months
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year. Limited to once every 6 months, following active therapy, exclusive of gross debridement
9.		
10.	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 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.
11.	REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (MAJOR RESTORATIVE SERVICES) CROWNS RETAINERS/ABUTMENTS	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. Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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.	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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered

	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
10.	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.
11.	Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
12.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 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.
- 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.
- Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 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.

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:

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

- 1. The following are not Covered orthodontic benefits:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Voluntary 140C/covered dental services

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ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0425	DISEASES - SPECIMEN ANALYSIS CARIES SUSCEPTIBILITY TESTS	\$0
	REPORT		D0423	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0451	PULP VITALITY TESTS	\$0
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0400	DIAGNOSTIC CASTS	\$0 \$0
D0180	VISIT COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5		REPORT	
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0		PREP/REPORT	
	IMAGES	**	D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	\$5
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	MARG PREP/REPORT CARIES RISK ASSESSMENT AND	\$0
	IMAGE			DOCUMENTATION, LOW	**
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
D0240	RADIOGRAPHIC IMAGE INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0		DOCUMENTATION, MODERATE	
D0240	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0 \$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0230	IMAGE	ΨΟ		DOCUMENTATION, HIGH	
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
	RADIOGRAPHIC IMAGE		D0702	CAPTURE ONLY 2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE –	\$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0102	IMAGE CAPTURE ONLY	ΨΟ
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0		RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0		IMAGE CAPTURE ONLY	
	IMAGES		D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0	D0700	IMAGE-IMAGE CAPTURE ONLY	\$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE- IMAGE CAPTURE ONLY	20
D0364	ACQUISITION, MEASUREMENT AND ANALYSIS	\$15	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
D0304	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF	φισ		RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	**
	VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$5
D0365	CONE BEAM CT CAPTURE AND	\$15	PREVEN	ITIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D1110 ¹	PROPHYLAXIS - ADULT	\$0
	OF ONE FULL DENTAL ARCH-MANDIBLE		D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$20		6 MONTHS	
	INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA		D11201	PROPHYLAXIS - CHILD	\$0
D0367	CONE BEAM CT CAPTURE AND	\$20	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
2000.	INTERPRETATION WITH FIELD OF VIEW OF BOTH	424	D4000	MONTHS TOPIONAL FLUORIDE MARNIOU	40
	JAWS		D1206	TOPICALFLUORIDE VARNISH	\$0
D0368	CONE BEAM CT CAPTURE AND	\$20	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
	INTERPRETATION FOR TMJ SERIES INCLUDING		D1310	EXCLUDING VARNISH NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0004	TWO OR MORE EXPOSURES	Δ-	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0	D1351	SEALANT - PER TOOTH	\$5
	SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
	TRANSMISSION OF WRITTEN REPORT		21002	CARIES RISK PATIENT- PERM TOOTH	Ψισ
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION – PER TOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$175
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$175
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$175
D1520	SPACE MAINTAINER -	\$35	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$175
D1526	REMOVABLE-UNILATERAL/QUAD SPACE MAINTAINER - REMOVABLE - BILATERAL,	\$35	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$175
D1527	MAXILLARY SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$35	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$175
D1551	RECEM/REBOND BILATERAL SPACE	\$5	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$125
D1552	MAINTAINER – MAXIL RECEM/REBOND BILATERAL SPACE	\$5	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	\$125
	MAINTAINER – MANDIB	**	D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	\$175*
D1553	RECEM/REBOND UNILATERAL SPACE	\$5	D2721	CROWN - RESIN W/PREDOM BASE METAL	\$175*
	MAINTAINER/QUAD		D2722*	CROWN - RESIN WITH NOBLE METAL	\$175*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$10	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$225*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$175*
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$10	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$175*
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$10	D2752*	METAL CROWN - PORCELAIN FUSED NOBLE METAL	\$175*
D1575	MAINTAINER-MANDIB DISTAL SHOE SPACE MAINTAINER – FIXED,	\$25	D2753	CROWN PORCELAIN FUSED TO	\$175
	UNILATERAL/QUAD		D0700*	TITANIUM/TITANIUM ALLOYS	0475 *
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$5	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$175*
DECTOR	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$175*
	ATIVE SERVICES	40	D2782* D2783	CROWN - 3/4 CAST NOBLE METAL CROWN - 3/4 PORCELAIN/CERAMIC	\$175* \$175*
D2140	AMALGAM - ONE SURFACE	\$0	D2703 D2790*	CROWN - 5/4 PORCELAIN/CERAWIC CROWN - FULL CAST HIGH NOBLE METAL	\$175 \$175*
D2150	PRIMARY/PERMANENT AMALGAM - TWO SURFACES	\$0	D2790 D2791	CROWN - FULL CAST PREDOM BASE METAL	\$175*
B2100	PRIMARY/PERMANENT	Ψ	D2791*	CROWN - FULL CAST NOBLE METAL	\$175*
D2160	AMALGAM - 3 SURFACES	\$0	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$175*
D2161	PRIMARY/PERMAMENT AMALGAM - FOUR/MORE SURFACES	\$0	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$0
	PRIMARY/PERMANENT	·	D2915	OR PART COV REST RECEMENT OR RE-BOND INDIRECTLY	\$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0		FABRICATED PREFABRICATED POST & CORE	
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0	D2920	RECEMENT OR RE-BOND CROWN	\$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$25	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$30		PRIMARY	
D2392 D2393	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$40	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$55 \$55	D2932	PERMANENT PREFABRICATED RESIN CROWN	\$35
D2594 D2510	RESIN COMPOSITE - 4/MORE SURFACES POST INLAY - METALLIC - ONE SURFACE	ანე \$150	D2933		\$35
D2510	INLAY - METALLIC - ONE SURFACES	\$150 \$150	D2000	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	ΨΟΟ
D2530	INLAY - METALLIC - 1/WO SURFACES	\$150 \$150	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - J/MORE SORI ACES	\$150 \$150		STEEL CROWN - PRIMARY	
D2542	ONLAY - METALLIC THREE SURFACES	\$150 \$150	D2940	SEDATIVE FILLING	\$0
D2543	ONLAY - METALLIC THREE SURFACES ONLAY - METALLIC FOUR OR MORE SURFACES	\$150 \$150	D2941	INTERIM THERAPEUTIC RESTORATION -	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$175*	B 22 = 2	PRIMARY DENTITION	A -
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$175*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$25
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$175*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$10
	SURFACES	4	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$35
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$175*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$25
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$175*	D2954	TOOTH PREFABRICATED POST & CORE ADDITION	\$20
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$175*	22007	CROWN	Ψ20

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	RATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962		\$600*		MOLAR	
D2302	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	φουσ	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$35	D3911	INTRAORIFICE BARRIER	\$30
B2011	XST PART DENTURE	ΨΟΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	OONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	\$115
ENDOD	SURFACE LESIONS DNTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$75
		Φ0		TEETH QUAD	
D3110	PULP CAP - DIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$0		PROC/TOOTH	
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$140
D2004	JUNC	045	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$85
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$15	D4245	APICALLY POSITIONED FLAP	\$165
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$115
			D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$325
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$25	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$215
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$25	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	TOOTH ANTERIOR	\$75	D 1200	NATURAL TOOTH – FIRST SITE IN QUADRANT	ΨΠΟ
		·	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$75
D3320	BICUSPID	\$150		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3330	MOLAR	\$275		QUADRANT	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$215
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$65	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$65
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$65		TOOTH (WHEN NOT PERFORMED IN	
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$100		CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$170		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$295	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$65	D 4070	TOOTH	0.75
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$65	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$65	D4322	TOOTH	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	ΨΙΟ
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
	MEDICAMENT REPLACEMENT			PROSTHETIC CROWNS	***
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4341	PERIODONTAL SCAL & ROOT PLAN	\$40t
	TREATMENT			4/>TEETH-QUAD	
D3410	APICOECTOMY SURG - ANT	\$95	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$28t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$25
D3425	APICOECTOMY SURG - MOLAR	\$95		MODERATE OR SEVERE GINGIVAL	
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION - FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$40t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900	D.1001	ON A SUBSEQUENT VISIT	A05 1
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE	\$35t
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$95		INTO DISEASED CREVICULAR TISSUE, PER TOOTH	
D2472	PREMOLAR	<u></u>	D4910	PERIODONTAL MAINTENANCE	\$30
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	\$95	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
	APICOECTOMY OR REPAIR ROOT		REMOV	ABLE PROSTHODONTIC SERVICES	
	RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$225*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$25*
D5120	COMPLETE DENTURE - MANDIBULAR	\$225*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$250*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$250*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$275*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$275*	DE740	MANDIBULAR	ФГ Г*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$275*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$55* \$55*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$275*	D5711 D5720	REBASE COMPLETE MANDIBULAR DENTURE	\$55*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$55*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$55* \$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$55 \$55
	MATERIALS, RESTS AND TEETH)		D5725	RELINE CMPL MAXIL DENTURE (DIRECT)	φ35*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$55*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$35*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$35*
D5223	MATERIALS, RESTS AND TEETH)	\$55*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$35*
D0220	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ΨΟΟ	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$55*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$55*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$55*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$55*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$55*	D5765	SOFT LINER FOR COMPLETE OR PART	\$10
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	Ψισ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$55*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$55*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$350*	D5850	TISSUE CONDITIONING MAXILLARY	\$10
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$350*	D5851	TISSUE CONDITIONING MANDIBULAR	\$10
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$55	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$55	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
D=000	DENTURE-FLEX BASE	***	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$260*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$55
D5283	MAXILLARY REMOVABLE UNILATERAL PARTIAL DENTURE -	\$260*		DENTURE (PER ARCH)	
D0200	MANDIBULAR	Ψ200	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$350	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	* 005
D5286	REMOVABLE UNILATERAL PARTIAL	\$350	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$0	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$0	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖ13
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$0	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$0		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$25*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$25*		CROWN	
D5520	MAXILLARY	\$25*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D0020	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	ΨΣΟ	D6060	METAL CROWN (HIGH NOBLE METAL)	¢610
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$25*	D0000	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$25*		METAL CROWN (NOBLE METAL)	,,,,,
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$25*		(HIGH NOBLE METAL)	
DEGOO	MANDIBULAR	₽ 0E*	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	\$25*	D0004*	(PREDOMINATELY BASE METAL)	4505
D5630	REPAIR OR REPLACE BROKEN CLASP - PER	\$25*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
	TOOTH		D6065	(NOBLE METAL) IMPLANT SUPPORTED PORCELAIN/CERAMIC	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$25*	20000	CROWN	φοσο
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$25*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)			DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	,
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH -	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	·
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40	D0404	TO TITANIUM/TITANIUM ALLOYS	***
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	φοσο
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	,	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$125*
D0000	ALLOYS	ψονο	D6211	PONTIC - CAST PREDOM BASE METAL	\$125*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$125*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$125*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$125*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$125*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$125*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$125*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	A
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$215*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$125*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$125*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$125*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED P	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$125*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$125*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	D0700*	BASE METAL	\$405 *
D6540	PROSTHESIS	¢200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$125* \$175*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC RETAINER CROWN - 3/4 TITANIUM/TITANIUM	\$175* \$125*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	ALLOYS RETAINER CROWN - 5/4 THANIOM/THANIOM/ ALLOYS	\$125*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$145*		METAL	
DCC04	SURFACES	Φ4.4 . Γ.*	D6791	RETAINER CROWN - FULL CAST	\$125*
D6601	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$145*	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$125*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2	\$115*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$125*
D.0000#	SURFACES	0 44=#		ALLOYS	
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	\$115*	D6920	CONNECTOR BAR	\$85
D6604	RETAINER INLAY - CAST PREDOM BASE METAL	\$115*	D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	\$0
	2 SURFACES		D6940	STRESS BREAKER	\$110
D6605	RETAINER INLAY - CAST PREDOM BASE METAL	\$115*	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$60
D6606*	3/>SURFACES RETAINER INLAY - CAST NOBLE METAL 2	\$115*	ORAL SI	JRGERY SERVICES	
D0000	SURFACES	φHJ	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$0
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$115*	D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$0
	SURFACES		D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$15
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$155*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	\$155*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$25
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2	\$115*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$50
	SURFACES		D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$75
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$115*	D7241	BONY DEMOVAL IMPACTED TOOTH, COMPLETELY	\$90
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL	\$150*	D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	ψθΟ
D0040	2 SURFACES	* 450*	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS	\$0
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$150*	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$115*	2.20.	REMOVAL	V.00
	SURFACES		D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL	\$115*	D7270	TOOTH REIMPLANTATION AND/OR	\$50
D6624*	3/MORE SURFACES RETAINER INLAY - TITANIUM	\$125*	D7000	STABILIZATION ACCIDENTLY DISPLACED	Ф05
D6634*	RETAINER INLAY - TITANIUM	\$125*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	\$85
	COMPOSITE	****	D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$0
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE	\$125*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$0
D.0=0.4	METAL	440=*	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$125*	D7000	COLLECTION	***
D6722*	BASE METAL RETAINER CROWN - RESIN WITH NOBLE METAL	\$125*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$215*	D7290 D7310	SURGICAL REPOSITIONING OF TEETH	\$75
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$0 \$0
	HIGH NOBLE METAL		D7311	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$0 \$0
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$0
D6752*	PREDOMINANTLY BASE METAL	\$125*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
D0102	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	ΨΙΖΟ		(SECONDARY EPITHELIALIZATION)	
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$125*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	\$05
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$0
D1400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$0
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
	1.25 CM		D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$75		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$25	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$25	D9996	ENCOUNTER TELEPENTISTRY ASYMCHRONOLIS	\$0
D7485 D7510	REDUCTION OF OSSEOUS TUBEROSITY	\$25 \$15	D3330	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	ΨΟ
D7510 D7511	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$15 \$15		DENTIST FOR SUBSEQUENT REVIEW	
וונוע	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	φισ	D9999	BROKEN APPOINTMENT	\$10
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$0	D8090	ADOLESCENT DENTITION	\$1,895
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$15	D0090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	φ1,033
D7961	BUCCAL / LABIAL FRENECTOMY	\$0	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
D-7000	(FRENULECTOMY)	00		MONITOR GROWTH AND DEVELOPMENT	
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$0 \$0	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$0 \$35		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970 D7971	EXC HYPERPLASTIC TISSUE-PER ARCH EXCISION OF PERICORONAL GINGIVA	\$25 \$20	DOCOL	OF RETAINERS)	\$450
D7971	SURGICAL RDUC FIBROUS TUBEROSITY	\$20 \$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF	\$150
	TIVE GENERAL SERVICES	φ40		TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$5	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
	ANESTHESIA				
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
D0000	15 MINUTES	A7 5			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
D9230	15 MINUTE INCREMENT ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
20200	NITROUS OXIDE	400			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
	SEDATION/ANESTHESIA - FIRST 15 MINUTES				
D9243	INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
	SEDATION/ANALGESIA - EACH 15 MINUTE				
D9248	INCREMENT NON-INTRAVENOUS (CONSCIOUS) SEDATION,	\$50			
	THIS INCLUDES NON-IV MINIMAL AND	***			
	MODERATE SEDATION				
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$0			

'Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

'Copays listed are also applicable in the specialist office.

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

'If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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This plan is underwritten by National Pacific Dental, Inc.

UnitedHealthcare/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 Benefit

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		• Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

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

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

- 8. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- 9. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 10. 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.
- 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Voluntary 140/covered dental services

ТХ	D092N	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0405	DISEASES - SPECIMEN ANALYSIS	20
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5		REPORT	
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	ФО.
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	\$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	MARG PREP/REPORT	\$0
	IMAGE		D0001	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	ΨΟ
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
	RADIOGRAPHIC IMAGE		50002	DOCUMENTATION, MODERATE	Ψů
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
	IMAGE		D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	
D0070	RADIOGRAPHIC IMAGE	Φ0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0		IMAGE CAPTURE ONLY	
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0		RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0	D	IMAGE CAPTURE ONLY	•
	IMAGES	•	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0	D0700	IMAGE-IMAGE CAPTURE ONLY	\$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	Φυ
D02C4	ACQUISITION, MEASUREMENT AND ANALYSIS	Ф4 Г	D0709	IMAGE CAPTURE ONLY INTRAORAL-COMPLETE SERIES OF	\$0
D0364	CONE BEAM CT CAPTURE AND	\$15	20100	RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	Ψ
	INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$0
D0365	CONE BEAM CT CAPTURE AND	\$15		ITIVE SERVICES	, ,
20000	INTERPRETATION WITH LIMITED FIELD OF VIEW	4.0	D1110¹	PROPHYLAXIS - ADULT	\$0
	OF ONE FULL DENTAL ARCH-MANDIBLE		D1110 ¹		\$25
D0366	CONE BEAM CT CAPTURE AND	\$20	DITIO	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	ΨΖΟ
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11201	PROPHYLAXIS - CHILD	\$0
	OF ONE FULL DENTAL ARCH-MAXILLA		D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
D0367	CONE BEAM CT CAPTURE AND	\$20	D1120	MONTHS	420
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	TOPICALFLUORIDE VARNISH	\$0
	JAWS		D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
D0368	CONE BEAM CT CAPTURE AND	\$20	2.200	EXCLUDING VARNISH	40
	INTERPRETATION FOR TMJ SERIES INCLUDING		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0201	TWO OR MORE EXPOSURES	¢E	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5 \$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	ΦU	D1351	SEALANT - PER TOOTH	\$5
	SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
	TRANSMISSION OF WRITTEN REPORT		D 1002	CARIES RISK PATIENT- PERM TOOTH	ΨΙΟ
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
		7.5	2.000		ΨΟ

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$175
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$175
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$175
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$35	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$175
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$35	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$175
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL,	\$35	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$175
D1551	MANDIBULAR RECEM/REBOND BILATERAL SPACE	\$5	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$125
D1552	MAINTAINER – MAXIL RECEM/REBOND BILATERAL SPACE	\$5	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	\$125
	MAINTAINER – MANDIB		D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	\$175*
D1553	RECEM/REBOND UNILATERAL SPACE	\$5	D2721	CROWN - RESIN W/PREDOM BASE METAL	\$175*
	MAINTAINER/QUAD		D2722*	CROWN - RESIN WITH NOBLE METAL	\$175*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$10	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$225*
D4557	MAINTAINER/QUAD	640	D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$175*
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$10	D2751	CROWN - PORCELAIN FUSED PREDOM BASE METAL	\$175*
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$10	D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$175*
D1575	MAINTAINER-MANDIB DISTAL SHOE SPACE MAINTAINER – FIXED,	\$25	D2753	CROWN PORCELAIN FUSED TO	\$175
D. 4.0.0.0	UNILATERAL/QUAD	**	D2780*	TITANIUM/TITANIUM ALLOYS CROWN - 3/4 CAST HIGH NOBLE METAL	\$175*
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$0	D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$175*
DESTOR	REPORT ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$175*
		40	D2783	CROWN - 3/4 CAST NOBLE METAL CROWN - 3/4 PORCELAIN/CERAMIC	\$175*
D2140	AMALGAM - ONE SURFACE	\$0			,
D2150	PRIMARY/PERMANENT	\$0	D2790*	CROWN - FULL CAST PREPOM PAGE METAL	\$175*
D2130	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	ΨΟ	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$175*
D2160	AMALGAM - 3 SURFACES	\$0	D2792*	CROWN - FULL CAST NOBLE METAL	\$175*
D2161	PRIMARY/PERMAMENT	\$0	D2794* D2910	CROWN - TITANIUM AND TITANIUM ALLOYS RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$175* \$0
	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	·	D2915	OR PART COV REST RECEMENT OR RE-BOND INDIRECTLY	\$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0		FABRICATED PREFABRICATED POST & CORE	
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0	D2920	RECEMENT OR RE-BOND CROWN	\$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$25	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$30		PRIMARY	
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$40	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$55		PERMANENT	
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$55	D2932	PREFABRICATED RESIN CROWN	\$35
D2510	INLAY - METALLIC - ONE SURFACE	\$150	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$35
D2520	INLAY - METALLIC - TWO SURFACES	\$150		RESIN WINDOW	
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$150	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$150	D0040	STEEL CROWN - PRIMARY	Φ0
D2543	ONLAY - METALLIC THREE SURFACES	\$150	D2940	SEDATIVE FILLING	\$0
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$150	D2941	INTERIM THERAPEUTIC RESTORATION –	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$175*	D2950	PRIMARY DENTITION CORE BUILDUP INCLUDING ANY PINS	\$25
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$175*	D2950 D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$23 \$10
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$175*	D2951 D2952	POST & CORE ADD CROWN INDIRECT FAB	\$35
	SURFACES				
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$175*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$25
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$175*	D2954	TOOTH DDEEADDICATED DOST & CODE ADDITION	\$20
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	\$175*	D23J4	PREFABRICATED POST & CORE ADDITION CROWN	φ20

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	RATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962		\$600*		MOLAR	
D2302	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	φουσ	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$35	D3911	INTRAORIFICE BARRIER	\$30
B2011	XST PART DENTURE	ΨΟΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	OONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	\$115
ENDOD	SURFACE LESIONS DNTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$75
		Φ0		TEETH QUAD	
D3110	PULP CAP - DIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$0		PROC/TOOTH	
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$140
D2004	JUNC	045	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$85
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$15	D4245	APICALLY POSITIONED FLAP	\$165
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$115
			D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$325
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$25	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$215
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$25	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	TOOTH ANTERIOR	\$75	D 1200	NATURAL TOOTH – FIRST SITE IN QUADRANT	ΨΠΟ
		·	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$75
D3320	BICUSPID	\$150		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3330	MOLAR	\$275		QUADRANT	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$215
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$65	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$65
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$65		TOOTH (WHEN NOT PERFORMED IN	
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$100		CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$170		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$295	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$65	D 4070	TOOTH	0.75
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$65	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$65	D4322	TOOTH	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	ΨΙΟ
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
	MEDICAMENT REPLACEMENT			PROSTHETIC CROWNS	***
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4341	PERIODONTAL SCAL & ROOT PLAN	\$40t
	TREATMENT			4/>TEETH-QUAD	
D3410	APICOECTOMY SURG - ANT	\$95	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$28t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$25
D3425	APICOECTOMY SURG - MOLAR	\$95		MODERATE OR SEVERE GINGIVAL	
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION - FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$40t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900	D.1001	ON A SUBSEQUENT VISIT	A05 1
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE	\$35t
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$95		INTO DISEASED CREVICULAR TISSUE, PER TOOTH	
D2472	PREMOLAR	<u></u>	D4910	PERIODONTAL MAINTENANCE	\$30
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	\$95	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
	APICOECTOMY OR REPAIR ROOT		REMOV	ABLE PROSTHODONTIC SERVICES	
	RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$225*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$25*
D5120	COMPLETE DENTURE - MANDIBULAR	\$225*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$250*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$250*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$275*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$275*	DE740	MANDIBULAR	ФГ Г*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$275*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$55* \$55*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$275*	D5711 D5720	REBASE COMPLETE MANDIBULAR DENTURE	\$55*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$55*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$55* \$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$55 \$55
	MATERIALS, RESTS AND TEETH)		D5725	RELINE CMPL MAXIL DENTURE (DIRECT)	φ35*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$55*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$35*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$35*
D5223	MATERIALS, RESTS AND TEETH)	\$55*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$35*
D0220	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ΨΟΟ	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$55*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$55*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$55*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$55*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$55*	D5765	SOFT LINER FOR COMPLETE OR PART	\$10
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	Ψισ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$55*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$55*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$350*	D5850	TISSUE CONDITIONING MAXILLARY	\$10
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$350*	D5851	TISSUE CONDITIONING MANDIBULAR	\$10
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$55	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$55	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
D=000	DENTURE-FLEX BASE	***	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$260*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$55
D5283	MAXILLARY REMOVABLE UNILATERAL PARTIAL DENTURE -	\$260*		DENTURE (PER ARCH)	
D0200	MANDIBULAR	Ψ200	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$350	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	* 005
D5286	REMOVABLE UNILATERAL PARTIAL	\$350	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$0	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$0	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖ13
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$0	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$0		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$25*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$25*		CROWN	
D5520	MAXILLARY	\$25*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D0020	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	ΨΣΟ	D6060	METAL CROWN (HIGH NOBLE METAL)	¢610
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$25*	D0000	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$25*		METAL CROWN (NOBLE METAL)	,,,,,
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$25*		(HIGH NOBLE METAL)	
DEGOO	MANDIBULAR	₽ 0E*	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	\$25*	D0004*	(PREDOMINATELY BASE METAL)	4505
D5630	REPAIR OR REPLACE BROKEN CLASP - PER	\$25*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
	TOOTH		D6065	(NOBLE METAL) IMPLANT SUPPORTED PORCELAIN/CERAMIC	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$25*	20000	CROWN	φοσο
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$25*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)			DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	,
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH -	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	·
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40	D0404	TO TITANIUM/TITANIUM ALLOYS	***
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	φοσο
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	,	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$125*
D0000	ALLOYS	ψονο	D6211	PONTIC - CAST PREDOM BASE METAL	\$125*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$125*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$125*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$125*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$125*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$125*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$125*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	A
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$215*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$125*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$125*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$125*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED P	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$125*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$125*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	DC700*	BASE METAL	¢40Γ*
D6E49	PROSTHESIS	¢200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$125* \$175*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$175* \$125*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	\$125*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$145*		RETAINER CROWN - FULL CAST HIGH NOBLE METAL	·
D6601	SURFACES	\$145*	D6791	RETAINER CROWN - FULL CAST	\$125*
D0001	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	ψ143	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$125*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2	\$115*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$125*
D6603*	SURFACES RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$115*	DC000	ALLOYS	фол
D0000	SURFACES	ΨΠΟ	D6920 D6930	CONNECTOR BAR	\$85 \$0
D6604	RETAINER INLAY - CAST PREDOM BASE METAL	\$115*		RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	•
D6605	2 SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$115*	D6940	STRESS BREAKER	\$110
	3/>SURFACES	****	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT URGERY SERVICES	\$60
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$115*	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$0
D6607*	SURFACES	\$115*	D7111	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$0 \$0
D0001	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	\$115	D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$15
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$155*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC	\$155*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$25
D6610*	3/MORE SURFACES RETAINER ONLAY - CAST HI NOBLE METAL 2	\$115*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$50
	SURFACES		D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$75
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$115*	D7241	BONY	\$90
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL	\$150*		REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	·
D6613	2 SURFACES	\$150*	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS	\$0
D0013	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$150	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$115*		REMOVAL	
DCC4E*	SURFACES	044 5 *	D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	\$115*	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$50
D6624*	RETAINER INLAY - TITANIUM	\$125*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634*	RETAINER ONLAY - TITANIUM	\$125*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$85
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$0
D6720*	COMPOSITE RETAINER CROWN - RESIN WITH HIGH NOBLE	\$125*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$0 \$0
	METAL		D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$125*		COLLECTION	
D6722*	BASE METAL RETAINER CROWN - RESIN WITH NOBLE METAL	\$125*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$215*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7310 D7311	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$0 \$0
	HIGH NOBLE METAL		D7311	ALVEOLOPLASTY CONSING XTRCT 1-3 TEETTI	\$0 \$0
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$0
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
20.02	NOBLE METAL	ų.23		(SECONDARY EPITHELIALIZATION)	**
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$125*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM	•	D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110		ARCH	
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
	1.25 CM		20054	ARCH	•
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$100	D9951	OCCLUSAL ADJUSTMENT - LIMITED	\$0
D7461	OR TUMOR - LESION DIAMETER UP TO 1.25 CM	¢125	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$0 \$105
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	1.25 CM		D9975	PERFORMED IN OFFICE	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$75	D0010	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	ψ123
D7472	REMOVAL OF TORUS PALATINUS	\$25	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$25		ENCOUNTER STREET	
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$25	D9996	TELEDENTISTRY - ASYNCHRONOUS;	\$0
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$15		INFORMATION STORED AND FORWARDED TO	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS	\$15		DENTIST FOR SUBSEQUENT REVIEW	
	COMPLICATED		D9999	BROKEN APPOINTMENT	\$10
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70		DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40	D0000	TRANSITIONAL DENTITION)	¢1 00E
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$0	D8090	ADOLESCENT DENTITION COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$15	20000	ADULT DENTITION	ψ.,σσσ
D7961	BUCCAL / LABIAL FRENECTOMY	\$0	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
D7000	(FRENULECTOMY)	Φ0		MONITOR GROWTH AND DEVELOPMENT	
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$0 \$0	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$0		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$25	D0000-	OF RETAINERS)	\$450
D7971	EXCISION OF PERICORONAL GINGIVA	\$20	D8999a	a o mater of the (intocobinto em an, beointainto	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY STIVE GENERAL SERVICES	\$40		RECORDS, X-RAYS, TRACING, PHOTOS, AND MODELS)	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$5		MODELEGY	
D9110	REGIONAL BLOCK ANESTHESIA	\$3 \$0			
D9211	TRIGEMINAL DIVISION BLOCK ANES	\$0 \$0			
D9212	LOCAL ANESTHESIA	\$0 \$0			
D9213		\$0 \$0			
	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA				
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	\$150			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
D9230	15 MINUTE INCREMENT ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
20200	NITROUS OXIDE	Ψ			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
D9243	SEDATION/ANESTHESIA - FIRST 15 MINUTES INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
	SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT				
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	\$50			
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$0			

¹Additional Prophy within 6 months will be based upon the necessity recommended by the provider.
²Copays listed are also applicable in the specialist office.
For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.
*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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UnitedHealthcare/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 Benefit

1.	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING	Limited to 4 quadrants per calendar year.
9.	PERIODONTAL MAINTENANCE	Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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.	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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES	(A) Pre-Authorized by us; and
	MUST BE	(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

- Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 10. 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.
- Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services. 11.
- Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 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.
- 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.
- Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Contributory 140C/covered dental services

TX D092C

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0425	DISEASES - SPECIMEN ANALYSIS CARIES SUSCEPTIBILITY TESTS	\$0
D0470	REPORT	Φ0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0 \$5	D0460	PULP VITALITY TESTS	\$0
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE VISIT	\$5	D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5		REPORT	
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT ACCESS TISSUE, GROSS & MICROSCOPIC SURG	\$5
D0000	IMAGES	Φ0	20	MARG PREP/REPORT	40
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	\$0	D0601	CARIES RISK ASSESSMENT AND	\$0
D0230	INTRAORL PERIAPICAL EACH ADD	\$0		DOCUMENTATION, LOW	
	RADIOGRAPHIC IMAGE	•	D0602	CARIES RISK ASSESSMENT AND	\$0
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	DOCUMENTATION, MODERATE	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0	D0003	CARIES RISK ASSESSMENT AND DOCUMENTATION. HIGH	φυ
D0054	IMAGE	•	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	
D0270	RADIOGRAPHIC IMAGE BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0
D0270	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	IMAGE CAPTURE ONLY	00
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0		IMAGE CAPTURE ONLY	**
	IMAGES		D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0		IMAGE-IMAGE CAPTURE ONLY	
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE- IMAGE CAPTURE ONLY	\$0
D0364	ACQUISITION, MEASUREMENT AND ANALYSIS CONE BEAM CT CAPTURE AND	\$15	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
D0004	INTERPRETATION WITH LIMITED FIELD OF	Ψισ		RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	
	VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$5
D0365	CONE BEAM CT CAPTURE AND	\$15	PREVEN	NTIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D1110 ¹	PROPHYLAXIS - ADULT	\$0
Dooce	OF ONE FULL DENTAL ARCH-MANDIBLE	#00	D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW	\$20		6 MONTHS	
	OF ONE FULL DENTAL ARCH-MAXILLA		D11201	PROPHYLAXIS - CHILD	\$0
D0367	CONE BEAM CT CAPTURE AND	\$20	D1120 ¹	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	MONTHS TOPICALFLUORIDE VARNISH	\$0
	JAWS		D1200	TOPICAL APPLICATION OF FLUORIDE -	\$0 \$0
D0368	CONE BEAM CT CAPTURE AND	\$20	D1200	EXCLUDING VARNISH	ΨΟ
	INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
	SPECIMEN TO INCLUDE CULTURE AND		D1351	SEALANT - PER TOOTH	\$5
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
DC 11=	TRANSMISSION OF WRITTEN REPORT	4-		CARIES RISK PATIENT- PERM TOOTH	
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION – PER TOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$175
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$25	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$175
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$25	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$175
D1520	SPACE MAINTAINER -	\$35	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$175
D1526	REMOVABLE-UNILATERAL/QUAD SPACE MAINTAINER - REMOVABLE - BILATERAL,	\$35	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$175
D1527	MAXILLARY SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$35	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$175
D1551	RECEM/REBOND BILATERAL SPACE	\$5	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$125
D1552	MAINTAINER – MAXIL RECEM/REBOND BILATERAL SPACE	\$5	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	\$125
	MAINTAINER – MANDIB	**	D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	\$175*
D1553	RECEM/REBOND UNILATERAL SPACE	\$5	D2721	CROWN - RESIN W/PREDOM BASE METAL	\$175*
	MAINTAINER/QUAD		D2722*	CROWN - RESIN WITH NOBLE METAL	\$175*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$10	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$225*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$175*
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$10	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$175*
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$10	D2752*	METAL CROWN - PORCELAIN FUSED NOBLE METAL	\$175*
D1575	MAINTAINER-MANDIB DISTAL SHOE SPACE MAINTAINER – FIXED,	\$25	D2753	CROWN PORCELAIN FUSED TO	\$175
	UNILATERAL/QUAD		D0700*	TITANIUM/TITANIUM ALLOYS	0475 *
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$5	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$175*
DECTOR	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$175*
	ATIVE SERVICES	40	D2782* D2783	CROWN - 3/4 CAST NOBLE METAL CROWN - 3/4 PORCELAIN/CERAMIC	\$175* \$175*
D2140	AMALGAM - ONE SURFACE	\$0	D2703 D2790*	CROWN - 5/4 PORCELAIN/CERAWIC CROWN - FULL CAST HIGH NOBLE METAL	\$175 \$175*
D2150	PRIMARY/PERMANENT AMALGAM - TWO SURFACES	\$0	D2790 D2791	CROWN - FULL CAST PREDOM BASE METAL	\$175*
DETOO	PRIMARY/PERMANENT	Ψ	D2791*	CROWN - FULL CAST NOBLE METAL	\$175*
D2160	AMALGAM - 3 SURFACES	\$0	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$175*
D2161	PRIMARY/PERMAMENT AMALGAM - FOUR/MORE SURFACES	\$0	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$0
	PRIMARY/PERMANENT	·	D2915	OR PART COV REST RECEMENT OR RE-BOND INDIRECTLY	\$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0		FABRICATED PREFABRICATED POST & CORE	
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0	D2920	RECEMENT OR RE-BOND CROWN	\$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$25	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$30		PRIMARY	
D2392 D2393	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$40	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$25
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$55 \$55	D2932	PERMANENT PREFABRICATED RESIN CROWN	\$35
D2594 D2510	RESIN COMPOSITE - 4/MORE SURFACES POST INLAY - METALLIC - ONE SURFACE	ანე \$150	D2933		\$35
D2510	INLAY - METALLIC - ONE SURFACES	\$150 \$150	D2000	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	ΨΟΟ
D2530	INLAY - METALLIC - 1/WO SURFACES	\$150 \$150	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - J/MORE SORI ACES	\$150 \$150		STEEL CROWN - PRIMARY	
D2542	ONLAY - METALLIC THREE SURFACES	\$150 \$150	D2940	SEDATIVE FILLING	\$0
D2543	ONLAY - METALLIC THREE SURFACES ONLAY - METALLIC FOUR OR MORE SURFACES	\$150 \$150	D2941	INTERIM THERAPEUTIC RESTORATION -	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$175*	B 22 = 2	PRIMARY DENTITION	A -
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$175*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$25
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$175*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$10
	SURFACES	4	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$35
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$175*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$25
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$175*	D2954	TOOTH PREFABRICATED POST & CORE ADDITION	\$20
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$175*	22007	CROWN	Ψ20

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	RATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$30		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962		\$600*		MOLAR	
D2302	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	φουσ	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$35	D3911	INTRAORIFICE BARRIER	\$30
B2011	XST PART DENTURE	ΨΟΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$90
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	OONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	\$115
ENDOD	SURFACE LESIONS DNTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$75
		Φ0		TEETH QUAD	
D3110	PULP CAP - DIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$0		PROC/TOOTH	
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$140
D2004	JUNC	045	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$85
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$15	D4245	APICALLY POSITIONED FLAP	\$165
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$115
			D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$325
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$25	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$215
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$25	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	TOOTH ANTERIOR	\$75	D 1200	NATURAL TOOTH – FIRST SITE IN QUADRANT	ΨΠΟ
		·	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$75
D3320	BICUSPID	\$150		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3330	MOLAR	\$275		QUADRANT	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$85	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$215
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$65	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$65
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$65		TOOTH (WHEN NOT PERFORMED IN	
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$100		CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$170		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$295	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$65	D 4070	TOOTH	0.75
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$65	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$65	D4322	TOOTH	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	ΨΙΟ
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
	MEDICAMENT REPLACEMENT			PROSTHETIC CROWNS	***
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4341	PERIODONTAL SCAL & ROOT PLAN	\$40t
	TREATMENT			4/>TEETH-QUAD	
D3410	APICOECTOMY SURG - ANT	\$95	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$28t
D3421	APICOECTOMY SURG-BICUSPID	\$95	D4346	SCALING IN PRESENCE OF GENERALIZED	\$25
D3425	APICOECTOMY SURG - MOLAR	\$95		MODERATE OR SEVERE GINGIVAL	
D3426	APICOECTOMY SURGERY	\$55		INFLAMMATION - FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$55		EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$95	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$40t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900	D.1001	ON A SUBSEQUENT VISIT	A05 1
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	\$95	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE	\$35t
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$95		INTO DISEASED CREVICULAR TISSUE, PER TOOTH	
D2472	PREMOLAR	ሶ ርር	D4910	PERIODONTAL MAINTENANCE	\$30
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	\$95	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
	APICOECTOMY OR REPAIR ROOT		REMOV	ABLE PROSTHODONTIC SERVICES	
	RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$225*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$25*
D5120	COMPLETE DENTURE - MANDIBULAR	\$225*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$250*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$250*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$275*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$150*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$275*	DE740	MANDIBULAR	ФГ Г*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$275*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$55* \$55*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$275*	D5711 D5720	REBASE COMPLETE MANDIBULAR DENTURE	\$55*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$55*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$55* \$55*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$55 \$55
	MATERIALS, RESTS AND TEETH)		D5725	RELINE CMPL MAXIL DENTURE (DIRECT)	φ35*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$55*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$35*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$35*
D5223	MATERIALS, RESTS AND TEETH)	\$55*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$35*
D0220	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ΨΟΟ	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$55*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$55*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$55*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$55*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$55*	D5765	SOFT LINER FOR COMPLETE OR PART	\$10
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	Ψισ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$55*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$55*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$350*	D5850	TISSUE CONDITIONING MAXILLARY	\$10
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$350*	D5851	TISSUE CONDITIONING MANDIBULAR	\$10
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$55	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$55	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
D=000	DENTURE-FLEX BASE	***	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$260*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$55
D5283	MAXILLARY REMOVABLE UNILATERAL PARTIAL DENTURE -	\$260*		DENTURE (PER ARCH)	
D0200	MANDIBULAR	Ψ200	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$350	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	* 005
D5286	REMOVABLE UNILATERAL PARTIAL	\$350	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$0	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$0	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖ13
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$0	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$0		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$25*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$25*		CROWN	
D5520	MAXILLARY	\$25*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D0020	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	ΨΣΟ	D6060	METAL CROWN (HIGH NOBLE METAL)	¢610
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$25*	D0000	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$25*		METAL CROWN (NOBLE METAL)	,,,,,
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$25*		(HIGH NOBLE METAL)	
DEGOO	MANDIBULAR	₽ 0E*	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	\$25*	D0004*	(PREDOMINATELY BASE METAL)	4505
D5630	REPAIR OR REPLACE BROKEN CLASP - PER	\$25*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
	TOOTH		D6065	(NOBLE METAL) IMPLANT SUPPORTED PORCELAIN/CERAMIC	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$25*	20000	CROWN	φοσο
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$25*			

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLAN ¹	SERVICES	-	D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	PORCELAIN/CERAMIC FPD ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	\$275
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	\$245
D6072*	METAL) ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	\$635	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	\$875
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	\$595	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH –	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	\$630	D6112	MANDIBULAR IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615	DOTTE	DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	ψ07-5
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH	\$875
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	\$630	D6120	MANDIBULAR IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40	D6121	TO TITANIUM/TITANIUM ALLOYS	\$630
	PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND		D6121	IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS	\$630
D6081	ABUTMENTS SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t		IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	·
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE		D6123	IMPLANT SUPPT RETAINER FOR METAL FPD-TITANIUM/TITANIUM ALLOYS	\$630
50000	IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	***	D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	\$145
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6192 D6194	SEMI-PRECISION ATTACHMENT – PLACEMENT ABUTMENT SUPPORTED RETAINER CROWN	\$220 \$545
D6084	NOBLE ALLOYS IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	FOR FPD - TITANIUM AND TITANIUM ALLOYS ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
D6086	TITANIUM/TITANIUM ALLOYS IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	FUSED TO TITANIUM/TITANIUM ALLOYS PROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210* D6211	PONTIC - CAST HIGH NOBLE METAL PONTIC - CAST PREDOM BASE METAL	\$125* \$125*
D6090	ALLOYS REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$125*
D6001	REPORT	¢ስስ	D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$125*
D6091	REPLCMT OF REPLCEABLE PART OF SEMI-PRECISION/PRECISION ATTCHMT OF IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER	\$90	D6240* D6241	PONTIC - PORCELAIN FUSED HI NOBLE METAL PONTIC - PORCELAIN FUSED PREDOM BASE METAL	\$125* \$125*
	ATTCHMT		D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$125*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	\$60	D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$125*
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	\$70	D6245	PONTIC - PORCELAIN/CERAMIC	\$215*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250* D6251	PONTIC - RESIN W/HIGH NOBLE METAL PONTIC RESIN W/PREDOM BASE METAL	\$125* \$125*
D6095	AND TITANIUM ALLOYS REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$125*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED P	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$125*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$125*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	DC700*	BASE METAL	₾40 E*
D6E49	PROSTHESIS	¢200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$125* \$175*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$175° \$125*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	\$125*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$145*		RETAINER CROWN - FULL CAST HIGH NOBLE METAL	·
D6601	SURFACES	\$145*	D6791	RETAINER CROWN - FULL CAST	\$125*
D0001	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	ψ1 4 5	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$125*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2	\$115*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$125*
D6603*	SURFACES RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$115*	DC000	ALLOYS	¢ος
D0000	SURFACES	ΨΠΟ	D6920 D6930	CONNECTOR BAR	\$85 \$0
D6604	RETAINER INLAY - CAST PREDOM BASE METAL	\$115*		RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	•
D6605	2 SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$115*	D6940	STRESS BREAKER	\$110
	3/>SURFACES	****	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT URGERY SERVICES	\$60
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$115*	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$0
D6607*	SURFACES	\$115*	D7111	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$0 \$0
D0001	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	\$115	D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$15
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$155*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC	\$155*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$25
D6610*	3/MORE SURFACES RETAINER ONLAY - CAST HI NOBLE METAL 2	\$115*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$50
	SURFACES	·	D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$75
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$115*	D7241	BONY	\$90
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL	\$150*		REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	·
D6613	2 SURFACES	¢450*	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS	\$0
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$150*	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$115*		REMOVAL	
DCC4E*	SURFACES	Ф44 Г *	D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	\$115*	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$50
D6624*	RETAINER INLAY - TITANIUM	\$125*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634*	RETAINER ONLAY - TITANIUM	\$125*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$85
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$0
D6720*	COMPOSITE RETAINER CROWN - RESIN WITH HIGH NOBLE	\$125*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$0 \$0
	METAL	·	D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$125*		COLLECTION	
D6722*	BASE METAL RETAINER CROWN - RESIN WITH NOBLE METAL	\$125*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$215*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7310 D7311	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$0 \$0
	HIGH NOBLE METAL		D7311	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$0 \$0
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$0
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
	NOBLE METAL	Ţ. <u>_</u> 3	D70-0	(SECONDARY EPITHELIALIZATION)	***
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$125*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	* 0.5
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$0
D1400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$0
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
	1.25 CM		D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$75		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$25	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$25	D9996	ENCOUNTER TELEPENTISTRY ASYMCHRONOLIS	\$0
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$25	D3330	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	ΨΟ
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$15		DENTIST FOR SUBSEQUENT REVIEW	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	\$15	D9999	BROKEN APPOINTMENT	\$10
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$0	Denon	ADOLESCENT DENTITION	¢1 00E
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$15	D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	\$1,895
D7961	BUCCAL / LABIAL FRENECTOMY	\$0	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
	(FRENULECTOMY)			MONITOR GROWTH AND DEVELOPMENT	,
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$0	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$0		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$25	D0005	OF RETAINERS)	0.450
D7971	EXCISION OF PERICORONAL GINGIVA	\$20	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY ETIVE GENERAL SERVICES	\$40		FOR REASONS OTHER THAN COMPLETION OF TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$5	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
	ANESTHESIA				
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
D0000	15 MINUTES	^- -			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
D9230	15 MINUTE INCREMENT ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
D3230	NITROUS OXIDE	ΨΟΟ			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
	SEDATION/ANESTHESIA - FIRST 15 MINUTES				
D9243	INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
	SEDATION/ANALGESIA - EACH 15 MINUTE				
D9248	INCREMENT	\$50			
D3240	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND	ΨΟΟ			
	MODERATE SEDATION				
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$0			

'Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

'Copays listed are also applicable in the specialist office.

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

'If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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This plan is underwritten by National Pacific Dental, Inc.

UnitedHealthcare/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 Benefit

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

LIMITATIONS OF BENEFITS

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

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

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
10.	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

- 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

EXCLUSIONS OF BENEFITS

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

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

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:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Contributory 150/covered dental services

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0405	DISEASES - SPECIMEN ANALYSIS	00
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0473	REPORT	\$0
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC - PREP/REPORT	ΨΟ
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	\$0
	IMAGES			MARG PREP/REPORT	, ,
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	CARIES RISK ASSESSMENT AND	\$0
D0000	IMAGE	Φ0		DOCUMENTATION, LOW	
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
D0240	RADIOGRAPHIC IMAGE INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0		DOCUMENTATION, MODERATE	
D0240		\$0 \$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0230	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	φυ		DOCUMENTATION, HIGH	
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0201	RADIOGRAPHIC IMAGE	Ψ	50-00	CAPTURE ONLY	•
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE –	\$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	IMAGE CAPTURE ONLY	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	Φ0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0	20100	IMAGE CAPTURE ONLY	Ψ0
DOLIT	IMAGES	Ψ	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0		IMAGE-IMAGE CAPTURE ONLY	
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	\$0
	ACQUISITION, MEASUREMENT AND ANALYSIS			IMAGE CAPTURE ONLY	
D0364	CONE BEAM CT CAPTURE AND	\$10	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
	INTERPRETATION WITH LIMITED FIELD OF			RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	
	VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$0
D0365	CONE BEAM CT CAPTURE AND	\$10	PREVEN	NTIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D1110 ¹	PROPHYLAXIS - ADULT	\$0
Doocc	OF ONE FULL DENTAL ARCH-MANDIBLE	Ф4 Г	D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$15		6 MONTHS	
	INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA		D1120 ¹	PROPHYLAXIS - CHILD	\$0
D0367	CONE BEAM CT CAPTURE AND	\$15	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
2000.	INTERPRETATION WITH FIELD OF VIEW OF BOTH	4.0	D. 4000	MONTHS	•
	JAWS		D1206	TOPICALFLUORIDE VARNISH	\$0
D0368	CONE BEAM CT CAPTURE AND	\$15	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
	INTERPRETATION FOR TMJ SERIES INCLUDING		D4240	EXCLUDING VARNISH	¢0
	TWO OR MORE EXPOSURES		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0 \$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
	SPECIMEN TO INCLUDE CULTURE AND		D1351	SEALANT - PER TOOTH	\$5
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
D0415	TRANSMISSION OF WRITTEN REPORT	¢Λ	D4353	CARIES RISK PATIENT- PERM TOOTH	ሱ ፫
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0 \$10	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION – PER TOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$125
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$15	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$125
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$15	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$125
D1520	SPACE MAINTAINER -	\$20	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$125
D1526	REMOVABLE-UNILATERAL/QUAD SPACE MAINTAINER - REMOVABLE - BILATERAL,	\$20	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$125
D1527	MAXILLARY SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$20	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$125
D1551	RECEM/REBOND BILATERAL SPACE	\$0	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$90
D1552	MAINTAINER – MAXIL RECEM/REBOND BILATERAL SPACE	\$0	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	\$90
	MAINTAINER – MANDIB	**	D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	\$125*
D1553	RECEM/REBOND UNILATERAL SPACE	\$0	D2721	CROWN - RESIN W/PREDOM BASE METAL	\$125*
	MAINTAINER/QUAD		D2722*	CROWN - RESIN WITH NOBLE METAL	\$125*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$10	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$215*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$125*
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$10	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$125*
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	\$10	D2752*	METAL CROWN - PORCELAIN FUSED NOBLE METAL	\$125*
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED,	\$15	D2753	CROWN PORCELAIN FUSED TO	\$125
	UNILATERAL/QUAD		D2780*	TITANIUM/TITANIUM ALLOYS CROWN - 3/4 CAST HIGH NOBLE METAL	\$125*
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$0	D2780 D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$125 \$125*
DESTOD	REPORT ATIVE SERVICES		D2781*	CROWN - 3/4 CAST PREDOM BASE METAL	\$125*
D2140		\$0	D2783	CROWN - 3/4 CAST NOBLE METAL CROWN - 3/4 PORCELAIN/CERAMIC	\$125*
DZ 140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	Φ0	D2790*	CROWN - 5/41 OROCLEAIN/OLIVAINIO	\$125*
D2150	AMALGAM - TWO SURFACES	\$0	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$125*
	PRIMARY/PERMANENT	**	D2792*	CROWN - FULL CAST NOBLE METAL	\$125*
D2160	AMALGAM - 3 SURFACES	\$0	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$125*
D2161	PRIMARY/PERMAMENT AMALGAM - FOUR/MORE SURFACES	\$0	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$0
D0000	PRIMARY/PERMANENT	# 0	D2915	OR PART COV REST RECEMENT OR RE-BOND INDIRECTLY	\$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0		FABRICATED PREFABRICATED POST & CORE	
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0	D2920	RECEMENT OR RE-BOND CROWN	\$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE A CUREACE POSTERIOR	\$20	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$10
D2391 D2392	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$25 \$35	D0004	PRIMARY	***
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$35 \$45	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$10
D2393	RESIN COMPOSITE - 4/MORE SURFACES POST	\$45	D2932	PERMANENT PREFABRICATED RESIN CROWN	\$10
D2534	INLAY - METALLIC - ONE SURFACE	\$115	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$20
D2520	INLAY - METALLIC - TWO SURFACES	\$115	22000	RESIN WINDOW	¥=v
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$115	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$115		STEEL CROWN - PRIMARY	
D2543	ONLAY - METALLIC THREE SURFACES	\$115	D2940	SEDATIVE FILLING	\$0
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$115	D2941	INTERIM THERAPEUTIC RESTORATION -	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$125*	B 22 = 2	PRIMARY DENTITION	A
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$125*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$10
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$125*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$8
	SURFACES	¥	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$20
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$125*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$10
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$125*	D2954	TOOTH PREFABRICATED POST & CORE ADDITION	\$10
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$125*	52007	CROWN	ψισ

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$15		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962		\$600*		MOLAR	
D2902	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	\$000	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$25	D3911	INTRAORIFICE BARRIER	\$25
DZOTT	XST PART DENTURE	ΨΣΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$75
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	OONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$50
	SURFACE LESIONS	, ,		TEETH QUAD	
ENDOD	ONTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$35
D3110	PULP CAP - DIRECT	\$0		TEETH QUAD	
D3120	PULP CAP - INDIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D. 40.40	PROC/TOOTH	^ =
	JUNC	**	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$115
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$5	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$85
	TEETH		D4245	APICALLY POSITIONED FLAP	\$155
D3222	PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$115
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$5	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$225
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$5	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$155
	TOOTH		D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	ANTERIOR	\$45		NATURAL TOOTH - FIRST SITE IN QUADRANT	
D3320	BICUSPID	\$75	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$75
D3330	MOLAR	\$115		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$65	D 4070	QUADRANT	¢405
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$45	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$195
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$45	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$50
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$70		TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$100		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$140	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$50		TOOTH	¥===
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$45	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$45		TOOTH	
			D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65		PROSTHETIC CROWNS	
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
D3357	MEDICAMENT REPLACEMENT	\$65		PROSTHETIC CROWNS	
D3331	PULPAL REGENERATION - COMPLETION OF TREATMENT	ΨΟΟ	D4341	PERIODONTAL SCAL & ROOT PLAN	\$25t
D3410	APICOECTOMY SURG - ANT	\$75	D.10.10	4/>TEETH-QUAD	A45 1
D3421	APICOECTOMY SURG-BICUSPID	\$75	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$15t
D3425	APICOECTOMY SURG - MOLAR	\$75	D4346	SCALING IN PRESENCE OF GENERALIZED	\$15
D3426	APICOECTOMY SURGERY	\$35		MODERATE OR SEVERE GINGIVAL	
D3430	RETROGRADE FILLING - PER ROOT	\$35		INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	
D3450	ROOT AMPUTATION - PER ROOT	\$75	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$25t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900		ON A SUBSEQUENT VISIT	
			D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL	\$55t
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	\$75		AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER	
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR	\$75	D4910	TOOTH PERIODONTAL MAINTENANCE	\$15
D3473	SURGICAL REPAIR OF ROOT RESORPTION -	\$75			
	MOLAR		D4920	UNSCHEDULED DRESSING CHANGE	\$0 \$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0
	APICOECTOMY OR REPAIR ROOT			ABLE PROSTHODONTIC SERVICES	A1=0:
	RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$150*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$15*
D5120	COMPLETE DENTURE - MANDIBULAR	\$150*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$150*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$125*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$150*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$115*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$125*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$115*	DE740	MANDIBULAR	Φ <i>4</i> Γ*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$165*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$45*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$165*	D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$45*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$45*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$45* \$45*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$45 \$45
	MATERIALS, RESTS AND TEETH)		D5723	RELINE CMPL MAXIL DENTURE (DIRECT)	\$0*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$45*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$0*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$0*
D5223	MATERIALS, RESTS AND TEETH)	\$45*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$0*
D0220	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ψ + 3	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$40*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$40*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$40*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$40*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$45*	D5765	SOFT LINER FOR COMPLETE OR PART	\$10
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	Ψίο
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$45*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$45*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$325*	D5850	TISSUE CONDITIONING MAXILLARY	\$10
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$325*	D5851	TISSUE CONDITIONING MANDIBULAR	\$10
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$45	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$45	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE	**-**	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$150*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$45
D5283	MAXILLARY	\$150*		DENTURE (PER ARCH)	
D0200	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	Ψ100	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$325	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	***
D5286	REMOVABLE UNILATERAL PARTIAL	\$325	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$0	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$0	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖΙΟ
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$0	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$0		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$15*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$15*		CROWN	
D5520	MAXILLARY	\$15*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	φισ	DCOCO	METAL CROWN (HIGH NOBLE METAL)	#C40
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$15*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$15*	2000.	METAL CROWN (NOBLE METAL)	Ų 000
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$15*		(HIGH NOBLE METAL)	
DEC00	MANDIBULAR	* 4.5*	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$15*	D 005 **	(PREDOMINATELY BASE METAL)	4-4-
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$15*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
_0000	TOOTH	Ψισ	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$15*	50000	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	φυσυ
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$15*		55111	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLAN	SERVICES	-	D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)		D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	\$630	D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	\$275
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	\$245
D6072*	METAL) ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	\$635	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	\$875
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	\$595	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH –	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		MANDIBULAR	
D6075	METAL FPD (NOBLE METAL) IMPLANT SUPPORTED RETAINER FOR CERAMIC	\$615	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH	\$875
D6076*	FPD IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$680	D6113	- MAXILLARY IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED,	\$40	D6121	TO TITANIUM/TITANIUM ALLOYS IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS IMPLANT SUPPT RETAINER FOR METAL	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE	\$180t	D6123	FPD-NOBLE ALLOYS IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE		D0120	FPD-TITANIUM/TITANIUM ALLOYS	Ψοσο
	IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	\$145
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT - PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	FUSED TO TITANIUM/TITANIUM ALLOYS PROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$125*
	ALLOYS		D6211	PONTIC - CAST PREDOM BASE METAL	\$125*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212* D6214*	PONTIC - CAST NOBLE METAL PONTIC - TITANIUM AND TITANIUM ALLOYS	\$125* \$125*
D6091	REPORT REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$125*
	SEMI-PRECISION/PRECISION ATTCHMT OF IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER	,	D6241	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	\$125*
	ATTCHMT		D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$125*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	\$60	D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$125*
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	D6245	PONTIC - PORCELAIN/CERAMIC	\$215*
D6094*	SUPPORTED FIXED PARTIAL DENTURE ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$125*
20007	AND TITANIUM ALLOYS	ΨΟΟΟ	D6251	PONTIC RESIN W/PREDOM BASE METAL	\$125*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$125*

PRIZEP PROSPHOSONIC SERVICES 107070 INTERNECT MODIC LITERATE PRESSION 107070 INTERNECT MODIC LITERATE PRESSION 107070 INTERNECT CORN ALTON CAST PREDOMINATITY 312° INTERNECT CORN ALTON CAST PREDOMINATITY AND ALTON	ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
OF DIAS PERCENT DIAM, MORESSON \$120	FIXED PI	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$125*
BASE METAL PROSINCES PRO	D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT	\$160		METAL	
PRICE PRIC		OF DIAG PRIOR TO FINAL IMPRESSION		D6781		\$125*
DESCRIPTION PROTECTION PROPERTY PROTECTION PROT	D6545		\$250	D6782*		¢125*
BOINCED PRICE PROSTHESIS 1879 1	D65/18		\$300*			·
RESIN RETAINER, FOR RESIN BONDED FIXED \$155 ALLOYS RETAINER, RILLAY - PORCELAINCERAMIC 2 \$145' PREDICTION FOR FOR FORM FOR FORM FOR FORM FULL CAST HIGH NOBLE \$125' PREDICTION FOR FORM FULL CAST HIGH NOBLE \$125' PREDICTION FULL CAST HIGH NOBLE \$125' PREDICTION FULL CAST HIGH NOBLE METAL 2 \$15' PREDICTION FULL CAST NOBLE METAL 3 \$125' PREDICTION FUL	D0340		φουσ			
PROSTHESIS	D6549		\$85	D0704		Ψ120
SURFACES SURFACES STATE PREDOMINANTLY BASE METALE STATE PREDOMINANTLY BASE METALE STATE PREDOMINANTLY BASE METALE STATE PREDOMINANTLY BASE METALE STATE		PROSTHESIS		D6790*		\$125*
RETAINER RILLY - PORCELAINCERAMIC \$145" REDOMINANTIV BROE NETAL \$125" RETAINER CROWN - FULL CAST NOBLE METAL \$125" RETAINER CROWN - FULL CAST NOBLE METAL \$125" ALLOYS SURFACES \$150" \$06393 RECEMBER RILLY - CAST HIN DOBLE METAL \$10" \$100 \$	D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$145*		METAL	
SMORE SURFACES STIP	D0004		0445*	D6791		\$125*
BETAINER INLAY - CAST HIN NOBLE METAL 2 \$115" D6791 RETAINER CROWN - TITANIUM AND TITANIUM \$125 SURFACES ALLOYS	D0001		\$145"	D6702*		¢125*
SURFACES	D6602*		\$115*			·
			·	D0134		Ψ120
RETAINER INLAY - CAST PREDOM BASE METAL \$115" D6840 STRESS BREAKER \$110 D6810 STRESS BREAKER \$110 D7810 STRESS BREAKER \$110 STRESS BRE	D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$115*	D6920		\$85
2 SURFACES				D6930	RECEMENT OR RE-BOND FIXED PARTIAL	\$0
D6808 RETAINER RILAY - CAST PREDOM BASE METAL \$115" D6808 FEMERALE D6808 FEMERACES D6808 FEMERACES D7410 EXTRACTION CROWNAL REMINANTS PRIMARY TOOTH \$0	D6604		\$115*		DENTURE	
SINTRACES CORRESPONDED NOTE INCENTRAL STATE CORRESPONDED NOTE INCOME. CORRESPO	Deene		¢11 <i>E</i> *	D6940	STRESS BREAKER	\$110
D6607 RETAINER NILAY - CAST NOBLE METAL 2 \$115" \$07110 XTRC CORONAL REMNANTS PRIMARY TOOTH \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$	D0003		\$115		•	\$60
SURFACES D7111 XTRCT CORONAL, REMNANTS PRINARY TOOTH \$0	D6606*		\$115*	ORAL SI		
No.			•		XTRCT CORONAL REMNANTS PRIMARY TOOTH	·
D6608 RETAINER ONLAY - PORCELAIN/CERAMIC 2 \$155" REMOVAL OF BONE ANDIOR SECTIONING OF SURFACES SURFACES TOOTH, AND INCLUDING ELEVATION OF SURFACES TOOTH, SOFT TISSUE \$25	D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE	\$115*		EXTRAC ERUPTED TOOTH/EXPOSED ROOT	
NUMBER STANSPORT STANSPO				D7210		\$15
De609 RETAINER ONLAY - PORCELAINICERAMIC \$155" \$10200 \$	D6608		\$155*			
MORE SURFACES 17220 REMOVAL IMPACT TOOTH - SOFT TISSUE 325 325 330 330 330 340 345	Deeno		¢155*		•	
B610¹ SURFAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES SURFACES SURFACES SURFACES SURFACES SURFACES D7240 REMOVAL IMPACTED TOOTH - COMPLETELY S70 BONY SURFACES BONY SURFACES BONY BONY SURFACES BONY BONY BONY BONY BONY BONY BONY BONY	D0009		\$100	D7220		\$25
D6611 RETAINER ONLAY - CAST HI NOBLE METAL 3/> SUPPORT	D6610*		\$115*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$50
SURFACES SURFACES SURFACES SURFACES SURFACES SURFACES SURFACES SUNFACES SURFACES SUNFACES				D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$75
D6612 BETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES 5150* BONY WISURG COMP D6613 BETAINER ONLAY - CAST PREDOM BASE METAL 3/SURFACES 5150* CUTTING PROCEDURE) (CUTTING PROCEDURE) D6614* BETAINER ONLAY - CAST NOBLE METAL 2 SURFACES 5115* REMOVAL PRIMARY CLOSURE OF A SINUS PERFORATION \$150* D6615* BETAINER ONLAY - CAST NOBLE METAL 3 SURFACES 5115* D7261 PRIMARY CLOSURE OF A SINUS PERFORATION \$225* D6615* BETAINER ONLAY - CAST NOBLE METAL 3 SURFACES 5115* D7270 TOOTH REIMPLANTATION ANDIOR SINUS PERFORATION \$50* D6624* BETAINER ONLAY - TITANIUM \$125* D7280 EXPOSURE OF AN UNERUPTED TOOTH \$85* D6701* BETAINER ORNOW - INDIRECT RESIN BASED COMPOSITIE COMPOSITIE COMPOSITIE COMPOSITIE BETAINER CROWN - RESIN WITH HIGH NOBLE \$125* D7280 MOBILIZATION OF ERUPTEO OR MALPOSITIONED \$80* D6720* BETAINER CROWN - RESIN WITH HOBILE METAL 5 \$125* D7286 INCISIONAL BIOPSY OF ORAL TISSUE HARD 5 \$20* D6722* BETAINER CROWN - RESIN WITH NOBLE METAL 5 \$125* D7280 EXTOLLATIVE CYTOLOGICAL SAMPLE 5 \$20* D6722* BETAINER CROWN - PORCELAIN FUSED TO 5 \$125* D7300 ALVEOLOPLASTY WIEXT 4/> TEETHISPACE 5 \$0	D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/>	\$115*		BONY	
2 SURFACES 5 POZSO REMOVAL OF RESIDUAL TOOTH ROOTS 50 D6613* RETAINER ONLAY - CAST PREDOM BASE METAL 3/150" CORONECTOMY - INTENTIONAL PARTIAL TOOTH 5150 D6614* RETAINER ONLAY - CAST NOBLE METAL 2 \$115" POZSO PRIMARY CLOSURE OF A SINUS PERFORATION \$225 D6615* RETAINER ONLAY - CAST NOBLE METAL 3 \$115" D7270 TOOTH REIMPLANTATION AND/OR \$50 D6624* RETAINER ONLAY - TITANIUM \$125" D7280 EXPOSURE OF AN UNREUPTED TOOTH \$85 D6634* RETAINER NILAY - TITANIUM \$125" D7280 EXPOSURE OF AN UNREUPTED TOOTH \$85 D6634* RETAINER ONLAY - TITANIUM \$125" D7280 EXPOSURE OF AN UNREUPTED TOOTH \$85 D6710 RETAINER ONLAY - TITANIUM \$125" D7280 EXPOSURE OF AN UNREUPTED TOOTH \$85 D6710 RETAINER CROWN - INDIRECT RESIN BASED \$185" TOOTH TO AID ERUPTION \$85 D6710 RETAINER CROWN - RESIN WITH HIGH NOBLE \$125" D7280 INCISIONAL BIOPSY OF ORAL TISSUE HARD \$0 D6720* RETAINER CROWN - RESIN WITH HIGH NOBLE \$125" D7280 SURGICAL SAMPLE \$20 D6721* RETAINER CROWN - RESIN WITH NOBLE METAL \$125" D7280 SURGICAL REPOSITIONING OF TEETH \$75 D6740 RETAINER CROWN - PORCELAIN FUSED TO \$125" D7310 ALVEOLOPLASTY WIEXT 4/s TEETH/SPACE \$0 D6750* RETAINER CROWN - PORCELAIN FUSED TO \$125" D7311 ALVEOLOPLASTY OR EXTAINER THE FIHSPACE \$0 D6751 RETAINER CROWN - PORCELAIN FUSED TO \$125" D7320 ALVEOLOPLASTY NOEXT 4/s TEETH/SPACE \$0 D6752* RETAINER CROWN - PORCELAIN FUSED TO \$125" D7310 ALVEOLOPLASTY NOEXT 4/s TEETH/SPACE \$0 D6753* RETAINER CROWN - PORCELAIN FUSED TO \$125" D7320 ALVEOLOPLASTY NOEXT 4/s TEETH/SPACE \$0 D6754* RETAINER CROWN - PORCELAIN FUSED TO \$125" D7320 ALVEOLOPLASTY NOEXT 4/s TEETH/SPACE \$0 D6755* RETAINER CROWN - PORCELAIN FUSED TO \$125" D7320 ALVEOLOPLASTY NOEXT 4/s TEETH/SPACE \$0 D6756* RETAINER CROWN - PORCELAIN FUSED TO \$125" D7320 ALVEOLOPLASTY NOEXT 4/s TEETH/SPACE \$0 D6756* RETAINER CROWN - PORCELAIN FUSED TO \$125" D7320 ALVEOLOPLASTY NOEXT 4/s TEETH/SPACE \$0 D6756* RETAINER CROWN - PORCELAIN FUSED TO \$125" D7320 ALVEOLOPLASTY NOEXT 4/s TEETH/SPACE \$0 D6756* RETAINER CROWN - PORCELAIN FUSED TO \$125" D7320 ALVEOLOPLASTY NOEXT 4/s TEETH/SPACE \$0 D6756*	D0040		A 0+	D7241		\$90
D6613 RETAINER ONLAY - CAST PREDOM BASE METAL \$150* COUTTING PROCEDURE) 3/5-SURFACES D7251 CORONECTOMY - INTENTIONAL PARTIAL TOOTH \$150 REMOVAL RE	D6612		\$150°	D7250		0.0
D6614* RETAINER CROWN - RESIN WITH HIGH NOBLE METAL S125* D7287 EXTOLICATIVE CROWN - RESIN WITH NOBLE METAL S125* D7287 EXTOLICATIVE CROWN - PORCELAIN FUSED TO S125* D7302 ALVEOLOPLASTY WIEXT 4/> TEETH/SPACE S07502 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL S125* D7304 ALVEOLOPLASTY NO EXT 4/> RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL S125* D7304 ALVEOLOPLASTY - RIDGE EXTENSION S215* D7304 ALVEOLOPLASTY - RIDGE EXTENSION S215* D7304 RETAINER CROWN - PORCELAIN FUSED TO S125* D7304 ALVEOLOPLASTY - RIDGE EXTENSION S215* D7305* ALVEOLOPLASTY - RIDGE EXTENSION S215* D7304 ALVEOLOPLASTY - RIDGE EXTENSION S215* D7305* D7305* ALVEOLOPLASTY - RIDGE EXTENSION S215* D7305*	D6613		\$150*	D1230		φυ
D6614* SURFACES RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES \$115* D7261 REMOVAL PRIMARY CLOSURE OF A SINUS PERFORATION \$225 D6615* RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES \$115* D7270 TOOTH REIMPLANTATION AND/OR SINUS PERFORATION \$50 D6624* RETAINER INLAY - TITANIUM \$125* D7280 EXPOSURE OF AN UNERUPTED TOOTH \$85 D6634* RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE \$185* TOOTH TO AID ERUPTED OR MALPOSITIONED \$85 D6720* RETAINER CROWN - RESIN WITH HIGH NOBLE METAL \$125* D7286 INCISIONAL BIOPSY OF ORAL TISSUE HARD \$0 D6721* RETAINER CROWN - RESIN WITH NOBLE METAL \$125* D7286 INCISIONAL BIOPSY OF ORAL TISSUE SOFT \$0 D6722* RETAINER CROWN - RESIN WITH NOBLE METAL \$125* D7288 BRUSH BIOPSY COLLECTION \$2 D6722* RETAINER CROWN - RESIN WITH NOBLE METAL \$125* D7290 SURGICAL REPOSITIONING OF TEETH \$7 D6724* RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL \$125* D7310 ALVEOLOPLASTY WIEXT 4/> TEETH/SPAC \$0 D6750* RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL \$125* D7311 ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC \$0 D6750* RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL \$125* D7321 ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC \$0 D6752*	200.0		V.00	D7251		\$150
D6615¹ ABCALLAY - CAST NOBLE METAL 3H15¹ ABCALLAY - TITANIUM 3H15² ABCALLAY - TITANIUM - TITANIUM 3H15² ABCALLAY - TITANIUM -	D6614*		\$115*			
3/MORE SURFACES 5/TABILIZATION ACCIDENTLY DISPLACED 5/TABILIZATION OF FREDITON ACCIDENTLY DISPLACED 5/TABILIZATION OF FREDIT DISPLA		SURFACES		D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6624* RETAINER INLAY - TITANIUM \$125* D7280 EXPOSURE OF AN UNERUPTED TOOTH \$85 D6634* RETAINER ONLAY - TITANIUM \$125* D7282 MOBILIZATION OF ERUPTED OR MALPOSITIONED \$85 D6710* RETAINER CROWN - INDIRECT RESIN BASED \$185* TOOTH TO AID ERUPTION \$0 COMPOSITE D7285 INCISIONAL BIOPSY OF ORAL TISSUE HARD \$0 METAL D7287 EXTOLIATIVE CYTOLOGICAL SAMPLE \$2 METAL D7288 BRUSH BIOPSY \$2 D6722* RETAINER CROWN - RESIN WITH NOBLE METAL \$125* D7288 BRUSH BIOPSY \$2 D6724* RETAINER CROWN - PORCELAIN FUSED TO \$125* D7290 SURGICAL REPOSITIONING OF TEETH \$75 D6740 RETAINER CROWN - PORCELAIN FUSED TO \$125* D7311 ALVEOLOPLASTY WIEXT 4/> TEETH/SPACE \$0 D6750* RETAINER CROWN - PORCELAIN FUSED TO \$125* D7320 ALVEOLOPLASTY NO BAXT 4/> TEETH/SPAC \$0 D6752* RETAINER CROWN - PORCELAIN FUSED TO \$125* D7321 ALVEOLOPLASTY NO W/XTRCT 1-3 TEETH \$0 <tr< td=""><td>D6615*</td><td></td><td>\$115*</td><td>D7270</td><td>TOOTH REIMPLANTATION AND/OR</td><td>\$50</td></tr<>	D6615*		\$115*	D7270	TOOTH REIMPLANTATION AND/OR	\$50
D6634* RETAINER ONLAY - TITANIUM \$125* D7282 MOBILIZATION OF ERUPTED OR MALPOSITIONED \$85 D6710 RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE D7285 INCISIONAL BIOPSY OF ORAL TISSUE HARD \$0 D7285 NECISIONAL BIOPSY OF ORAL TISSUE HARD \$0 NCISIONAL BIOPSY OF ORAL TISSUE SOFT \$0 NCISIONAL BIOPSY OF ORAL TISSUE HARD \$0 NCISIONAL BIOPSY OF ORAL TISSUE SOFT \$0 NCISIONA	D6604*		¢10E*	D7000		405
D6710 RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE D7285 INCISIONAL BIOPSY OF ORAL TISSUE HARD \$0 D7285 INCISIONAL BIOPSY OF ORAL TISSUE HARD \$0 D7285 INCISIONAL BIOPSY OF ORAL TISSUE HARD \$0 D7285 INCISIONAL BIOPSY OF ORAL TISSUE SOFT \$0 D7286 INCISIONAL BIOPSY OF ORAL TISSUE SOFT \$0 D7287 EXTOLIATIVE CYTOLOGICAL SAMPLE \$20 D7287 EXTOLIATIVE CYTOLOGICAL SAMPLE \$20 D7288 BRUSH BIOPSY						
COMPOSITE D7285 INCISIONAL BIOPSY OF ORAL TISSUE HARD \$0 D6720* RETAINER CROWN - RESIN WITH HIGH NOBLE METAL D7286 INCISIONAL BIOPSY OF ORAL TISSUE SOFT \$0 METAL D7287 EXTOLIATIVE CYTOLOGICAL SAMPLE \$20 D6721* RETAINER CROWN - RESIN PREDOMINANTLY \$125* COLLECTION BASE METAL D7288 BRUSH BIOPSY \$20 D6722* RETAINER CROWN - RESIN WITH NOBLE METAL \$125* D7290 SURGICAL REPOSITIONING OF TEETH \$75 D6740 RETAINER CROWN - PORCELAIN/CERAMIC \$215* D7310 ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE \$0 D6750* RETAINER CROWN - PORCELAIN FUSED TO \$125* D7311 ALVEOLOPLASTY ON EXT 4/> TEETH/SPAC \$0 D6751 RETAINER CROWN - PORCELAIN FUSED TO \$125* D7320 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH \$0 D6752* RETAINER CROWN - PORCELAIN FUSED TO \$125* D7321 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH \$0 D6753* RETAINER CROWN - PORCELAIN FUSED TO \$125* D7320 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH \$0 D6754* RETAINER CROWN - PORCELAIN FUSED TO \$125* D7320 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH \$0 D6755* RETAINER CROWN - PORCELAIN FUSED TO \$125* D7320 ALVEOLOPLASTY - RIDGE EXTENSION \$215 D6756* RETAINER CROWN - PORCELAIN FUSED TO \$125* D7350 YESTIBULOPLASTY - RIDGE EXTENSION \$215 D6757 RETAINER CROWN - PORCELAIN FUSED TO \$125* D7350 YESTIBULOPLASTY - RIDGE EXTENSION \$670 UNCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE			•	D1202		φοσ
D6720* RETAINER CROWN - RESIN WITH HIGH NOBLE METAL D7286 EXTOLIATIVE CYTOLOGICAL SAMPLE \$20 D6721 RETAINER CROWN - RESIN PREDOMINANTLY S125* COLLECTION BASE METAL D6722* RETAINER CROWN - RESIN WITH NOBLE METAL \$125* D7288 BRUSH BIOPSY \$20 D6722* RETAINER CROWN - PORCELAIN/CERAMIC \$215* D7290 SURGICAL REPOSITIONING OF TEETH \$75 D6740 RETAINER CROWN - PORCELAIN FUSED TO \$125* D7310 ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE \$0 D6750* RETAINER CROWN - PORCELAIN FUSED TO \$125* D7311 ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC \$0 D6751 RETAINER CROWN - PORCELAIN FUSED TO \$125* D7320 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH \$0 D6752* RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL D7320 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH \$0 D6752* RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL \$125* D7340 VESTIBULOPLASTY - RIDGE EXTENSION \$215 NOBLE METAL \$125* D7350 VESTIBULOPLASTY - RIDGE EXTENSION \$670 ITTANIUM/TITANIUM ALLOYS	D0110		ψιου	D7285		\$0
D6721 RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL D7288 BRUSH BIOPSY RETAINER CROWN - RESIN WITH NOBLE METAL D6740 RETAINER CROWN - PORCELAIN/CERAMIC D6750* RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL D6751 RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL D6752* RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6753 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6754 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6755 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6756 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6757 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6758 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6759 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6750 RETAINER CROWN - PORCELAIN FUSED TO ITITANIUM/TITANIUM ALLOYS EXCHANGE CROWN - PORCELAIN FUSED TO (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE	D6720*		\$125*			
D6721 RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL D7288 BRUSH BIOPSY \$20 D6722* RETAINER CROWN - RESIN WITH NOBLE METAL D6740 RETAINER CROWN - PORCELAIN/CERAMIC D6750* RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL D6751 RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL D6752* RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6753 RETAINER CROWN - PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS D7350 PORCELAIN FUSED TO NOBLE METAL RETAINER CROWN-PORCELAIN FUSED TO NOBLE METAL RETAINER CROWN-PO		METAL		D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6722* RETAINER CROWN - RESIN WITH NOBLE METAL \$125* D7290 SURGICAL REPOSITIONING OF TEETH \$75 D6740 RETAINER CROWN - PORCELAIN/CERAMIC \$215* D7310 ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE \$0 D6750* RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL D7320 ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC \$0 D6751 RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL D7321 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH \$0 D6752* RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL D7340 VESTIBULOPLASTY - RIDGE EXTENSION \$215 NOBLE METAL D6753 RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS TITANIUM/TITANIUM ALLOYS D7350 VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE	D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$125*			
D6740 RETAINER CROWN - PORCELAIN/CERAMIC \$215* D7310 ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE \$0 D6750* RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL D7320 ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC \$0 HIGH NOBLE METAL D7320 ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC \$0 PREDOMINANTLY BASE METAL D7321 ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC \$0 PREDOMINANTLY BASE METAL D7321 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH \$0 PREDOMINANTLY BASE METAL D7340 VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) D6753 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D7350 VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE	DC700*		¢40F*	D7288	BRUSH BIOPSY	\$20
D6750* RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL D7320 ALVEOLOPLASTY NO EXT 4/> TEETH/SPACE \$0 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH \$0 ALVEOLOPLASTY NOT W/XTR				D7290	SURGICAL REPOSITIONING OF TEETH	\$75
HIGH NOBLE METAL D6751 RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL D6752* RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6753 RETAINER CROWN-PORCELAIN FUSED TO NOBLE METAL D6754 RETAINER CROWN-PORCELAIN FUSED TO NOBLE METAL D6755 RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS TITANIUM/TITANIUM ALLOYS D7320 ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC D7321 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH \$0 D7320 VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE						•
D6751 RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL D6752* RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6753 RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS D7320 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH \$0 VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE	D0130		ر21 ب			·
PREDOMINANTLY BASE METAL D6752* RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL D6753 RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	D6751		\$125*			
NOBLE METAL D6753 RETAINER CROWN-PORCELAIN FUSED TO \$125* (SECONDARY EPITHELIALIZATION) TITANIUM/TITANIUM ALLOYS S125* (SECONDARY EPITHELIALIZATION) VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE			•			
D6753 RETAINER CROWN-PORCELAIN FUSED TO \$125* VESTIBULOPLASTY - RIDGE EXTENSION \$670 TITANIUM/TITANIUM ALLOYS (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE	D6752*	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D/340		\$215
TITANIUM/TITANIUM ALLOYS RETAINER CROWN-PORCELAIN FUSED TO \$125* VECTIODE IN TRIBUTE PROPERTY TO THE PORCELAIN FUSED TO \$125* (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE	D		A.A	D7350	,	\$670
REATTACHMENT, REVISION OF SOFT TISSUE	D6753		\$125*			40.0
ATTACHMENT		THANIUM/THANIUM ALLUYS			•	
					ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	\$05
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$0
D1400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$0
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
	1.25 CM		D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$75		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$25	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$25	D9996	ENCOUNTER TELEPENTISTRY ASYMCHRONOLIS	\$0
D7485 D7510	REDUCTION OF OSSEOUS TUBEROSITY	\$25 \$15	D3330	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	ΨΟ
D7510 D7511	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$15 \$15		DENTIST FOR SUBSEQUENT REVIEW	
וונוע	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	φισ	D9999	BROKEN APPOINTMENT	\$10
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$0	D8090	ADOLESCENT DENTITION	\$1,895
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$15	D0090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	φ1,033
D7961	BUCCAL / LABIAL FRENECTOMY	\$0	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
D-7000	(FRENULECTOMY)	00		MONITOR GROWTH AND DEVELOPMENT	
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$0 \$0	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$0 \$35		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970 D7971	EXC HYPERPLASTIC TISSUE-PER ARCH EXCISION OF PERICORONAL GINGIVA	\$25 \$20	DOCOL	OF RETAINERS)	\$450
D7971	SURGICAL RDUC FIBROUS TUBEROSITY	\$20 \$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF	\$150
	TIVE GENERAL SERVICES	φ40		TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$5	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
	ANESTHESIA				
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
D0000	15 MINUTES	A7 5			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
D9230	15 MINUTE INCREMENT ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
20200	NITROUS OXIDE	400			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
	SEDATION/ANESTHESIA - FIRST 15 MINUTES				
D9243	INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
	SEDATION/ANALGESIA - EACH 15 MINUTE				
D9248	INCREMENT NON-INTRAVENOUS (CONSCIOUS) SEDATION,	\$50			
	THIS INCLUDES NON-IV MINIMAL AND	***			
	MODERATE SEDATION				
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$0			

'Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

'Copays listed are also applicable in the specialist office.

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

'If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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LIMITATIONS OF BENEFITS

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

bene	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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.						
6.	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.						
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.						
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).						
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.						
10.	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.						

- 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

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:

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

- 1. The following are not Covered orthodontic benefits:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Voluntary 150C/covered dental services

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0405	DISEASES - SPECIMEN ANALYSIS	00
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0470	REPORT	40
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	PREP/REPORT	\$0
	IMAGES		D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	ΨΟ
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	CARIES RISK ASSESSMENT AND	\$0
	IMAGE		D0001	DOCUMENTATION, LOW	Ψ
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
	RADIOGRAPHIC IMAGE			DOCUMENTATION, MODERATE	**
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0		DOCUMENTATION, HIGH	
D00=4	IMAGE	**	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	
D0270	RADIOGRAPHIC IMAGE BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0
D0270		·		IMAGE CAPTURE ONLY	
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0		RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0	D0707	IMAGE CAPTURE ONLY	40
D0000	IMAGES	Φ0	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0	D0708	IMAGE-IMAGE CAPTURE ONLY	\$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0706	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	ΦΟ
D0364	ACQUISITION, MEASUREMENT AND ANALYSIS	\$10	D0709	IMAGE CAPTURE ONLY INTRAORAL—COMPLETE SERIES OF	\$0
D0364	CONE BEAM CT CAPTURE AND	\$10	20.00	RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	Ψ o
	INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$5
D0365	CONE BEAM CT CAPTURE AND	\$10	PREVEN	NTIVE SERVICES	, ,
20000	INTERPRETATION WITH LIMITED FIELD OF VIEW	4. .	D1110¹	PROPHYLAXIS - ADULT	\$0
	OF ONE FULL DENTAL ARCH-MANDIBLE		D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$15	DITIO	- PROPHYLAXIS - ADULT TADD, PROPHY WITHIN 6 MONTHS	ΨΖϽ
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11201	PROPHYLAXIS - CHILD	\$0
	OF ONE FULL DENTAL ARCH-MAXILLA		D1120 ¹	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
D0367	CONE BEAM CT CAPTURE AND	\$15	D1120	MONTHS	Ψ20
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	TOPICALFLUORIDE VARNISH	\$0
	JAWS	A	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
D0368	CONE BEAM CT CAPTURE AND	\$15		EXCLUDING VARNISH	**
	INTERPRETATION FOR TMJ SERIES INCLUDING		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	TWO OR MORE EXPOSURES INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
		\$5 \$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	ΦU	D1351	SEALANT - PER TOOTH	\$5
	SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
	TRANSMISSION OF WRITTEN REPORT		D 1002	CARIES RISK PATIENT- PERM TOOTH	ΨΙΟ
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10	2.000	APPLICATION – PER TOOTH	ΨΟ
D0411	COLLECTION & I NEF OF SALIVA SAMIFLE	φιυ		ALL LIGATION - FER TOUTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$125
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$15	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$125
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$15	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$125
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$20	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$125
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$20	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$125
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$20	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$125
D1551	RECEM/REBOND BILATERAL SPACE	\$0	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$90
D1552	MAINTAINER – MAXIL	\$0	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE	\$90
D 1002	RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB	Ψ	D2720*	INDIRECT CROWN - RESIN WITH HIGH NOBLE METAL	\$125*
D1553	RECEM/REBOND UNILATERAL SPACE	\$0	D2721	CROWN - RESIN W/PREDOM BASE METAL	\$125*
	MAINTAINER/QUAD		D2722*	CROWN - RESIN WITH NOBLE METAL	\$125*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$10	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$215*
D4557	MAINTAINER/QUAD	¢ 40	D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$125*
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$10	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$125*
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$10	D2752*	METAL CROWN - PORCELAIN FUSED NOBLE METAL	\$125*
D1575	MAINTAINER-MANDIB DISTAL SHOE SPACE MAINTAINER – FIXED,	\$15	D2753	CROWN PORCELAIN FUSED TO	\$125
	UNILATERAL/QUAD			TITANIUM/TITANIUM ALLOYS	
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$5	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$125*
	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$125*
	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$125*
D2140	AMALGAM - ONE SURFACE	\$0	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$125*
D2150	PRIMARY/PERMANENT	\$0	D2790*	CROWN - FULL CAST HIGH NOBLE METAL	\$125*
D2130	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	ΦО	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$125*
D2160	AMALGAM - 3 SURFACES	\$0	D2792* D2794*	CROWN - FULL CAST NOBLE METAL CROWN - TITANIUM AND TITANIUM ALLOYS	\$125* \$125*
D0101	PRIMARY/PERMAMENT	40	D2794 D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$125
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	\$0	D0045	OR PART COV REST	40
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0	D2915	RECEMENT OR RE-BOND INDIRECTLY	\$0
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0	D2920	FABRICATED PREFABRICATED POST & CORE RECEMENT OR RE-BOND CROWN	\$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$20	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$10
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$25	22000	PRIMARY	Ψ.0
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$35	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$10
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$45		PERMANENT	
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$45	D2932	PREFABRICATED RESIN CROWN	\$10
D2510	INLAY - METALLIC - ONE SURFACE	\$115	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$20
D2520	INLAY - METALLIC - TWO SURFACES	\$115	D2034	RESIN WINDOW	\$60
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$115	D2934	PREFABRICATED ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$115	D2940	SEDATIVE FILLING	\$0
D2543	ONLAY - METALLIC THREE SURFACES	\$115	D2941	INTERIM THERAPEUTIC RESTORATION –	\$5
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$115		PRIMARY DENTITION	
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$125*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$10
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$125*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$8
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	\$125*	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$20
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$125*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$10
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$125*	D2954	TOOTH	\$10
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$125*	D239 4	PREFABRICATED POST & CORE ADDITION CROWN	\$10

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$15		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962		\$600*		MOLAR	
D2902	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	\$000	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$25	D3911	INTRAORIFICE BARRIER	\$25
DZSTT	XST PART DENTURE	ΨΣΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$75
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	ONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$50
	SURFACE LESIONS	, ,		TEETH QUAD	
ENDODO	ONTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$35
D3110	PULP CAP - DIRECT	\$0		TEETH QUAD	
D3120	PULP CAP - INDIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D. 40.40	PROC/TOOTH	A =
	JUNC	**	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$115
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$5	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$85
	TEETH		D4245	APICALLY POSITIONED FLAP	\$155
D3222	PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$115
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$5	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$225
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$5	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$155
	TOOTH		D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	ANTERIOR	\$45		NATURAL TOOTH - FIRST SITE IN QUADRANT	
D3320	BICUSPID	\$75	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$75
D3330	MOLAR	\$115		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$65	D 4070	QUADRANT	#405
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$45	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$195
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$45	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$50
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$70		TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$100		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$140	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$50		TOOTH	
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$45	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$45		TOOTH	
			D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65		PROSTHETIC CROWNS	
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
D3357	MEDICAMENT REPLACEMENT	\$65		PROSTHETIC CROWNS	
ונסטטו	PULPAL REGENERATION - COMPLETION OF TREATMENT	φυσ	D4341	PERIODONTAL SCAL & ROOT PLAN	\$25t
D3410	APICOECTOMY SURG - ANT	\$75	D. 40.40	4/>TEETH-QUAD	A. = :
D3421	APICOECTOMY SURG-BICUSPID	\$75	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$15t
D3425	APICOECTOMY SURG - MOLAR	\$75	D4346	SCALING IN PRESENCE OF GENERALIZED	\$15
D3425	APICOECTOMY SURGERY	\$75 \$35		MODERATE OR SEVERE GINGIVAL	
				INFLAMMATION – FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$35 \$35	D4355	EVALUATION	\$25t
D3450	ROOT AMPUTATION - PER ROOT	\$75	D-1000	FULL MOUTH DEBRID COMP ORAL EVAL & DX ON A SUBSEQUENT VISIT	ΨΖΟί
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL	\$55t
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	\$75		AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER	,,,,,
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR	\$75	D4910	TOOTH PERIODONTAL MAINTENANCE	\$15
D3473	SURGICAL REPAIR OF ROOT RESORPTION -	\$75	D4920	UNSCHEDULED DRESSING CHANGE	\$0
B.C=1 :	MOLAR		D4920 D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0 \$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250		ABLE PROSTHODONTIC SERVICES	ΦU
	APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$150*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$15*
D5120	COMPLETE DENTURE - MANDIBULAR	\$150*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$150*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$125*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$150*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$115*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$125*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$115*	DE740	MANDIBULAR	Φ <i>4</i> Γ*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$165*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$45*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$165*	D5711 D5720	REBASE COMPLETE MANDIBULAR DENTURE	\$45*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$45*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$45* \$45*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$45 \$45
	MATERIALS, RESTS AND TEETH)		D5723	RELINE CMPL MAXIL DENTURE (DIRECT)	\$43 \$0*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$45*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$0*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$0*
D5223	MATERIALS, RESTS AND TEETH)	\$45*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$0*
D0220	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ψ + 3	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$40*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$40*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$40*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$40*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$45*	D5765	SOFT LINER FOR COMPLETE OR PART	\$10
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	Ψισ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$45*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$45*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$325*	D5850	TISSUE CONDITIONING MAXILLARY	\$10
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$325*	D5851	TISSUE CONDITIONING MANDIBULAR	\$10
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$45	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$45	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE	**-**	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$150*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$45
D5283	MAXILLARY	\$150*		DENTURE (PER ARCH)	
D0200	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	Ψ100	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$325	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	***
D5286	REMOVABLE UNILATERAL PARTIAL	\$325	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$0	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$0	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖΙΟ
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$0	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$0		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$15*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$15*		CROWN	
D5520	MAXILLARY	\$15*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	φισ	DCCC	METAL CROWN (HIGH NOBLE METAL)	ФС40
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$15*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$15*	2000.	METAL CROWN (NOBLE METAL)	Ų000
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$15*		(HIGH NOBLE METAL)	
DEC00	MANDIBULAR	* 4.5*	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$15*	B 222 ***	(PREDOMINATELY BASE METAL)	4-4-
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$15*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
_0000	TOOTH	Ψισ	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$15*	50003	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	φυσυ
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$15*		55	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)			DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	,
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH -	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	·
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40	D0404	TO TITANIUM/TITANIUM ALLOYS	***
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	φοσο
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	,	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$125*
D0000	ALLOYS	ψονο	D6211	PONTIC - CAST PREDOM BASE METAL	\$125*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$125*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$125*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$125*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$125*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$125*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$125*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	A
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$215*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$125*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$125*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$125*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED P	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$125*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$125*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	DC700*	BASE METAL	¢40Γ*
D6E49	PROSTHESIS	¢200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$125* \$175*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$175* \$125*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	\$125*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$145*		RETAINER CROWN - FULL CAST HIGH NOBLE METAL	·
D6601	SURFACES	\$145*	D6791	RETAINER CROWN - FULL CAST	\$125*
D0001	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	ψ143	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$125*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2	\$115*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$125*
D6603*	SURFACES RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$115*	DC000	ALLOYS	фол
D0000	SURFACES	ΨΠΟ	D6920 D6930	CONNECTOR BAR	\$85 \$0
D6604	RETAINER INLAY - CAST PREDOM BASE METAL	\$115*		RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	•
D6605	2 SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$115*	D6940	STRESS BREAKER	\$110
	3/>SURFACES	****	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT URGERY SERVICES	\$60
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$115*	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$0
D6607*	SURFACES	\$115*	D7111	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$0 \$0
D0001	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	\$115	D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$15
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$155*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC	\$155*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$25
D6610*	3/MORE SURFACES RETAINER ONLAY - CAST HI NOBLE METAL 2	\$115*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$50
	SURFACES		D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$75
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$115*	D7241	BONY	\$90
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL	\$150*		REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	·
D6613	2 SURFACES	\$150*	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS	\$0
D0013	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$150	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$115*		REMOVAL	
DCC4E*	SURFACES	044 5 *	D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	\$115*	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$50
D6624*	RETAINER INLAY - TITANIUM	\$125*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634*	RETAINER ONLAY - TITANIUM	\$125*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$85
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$0
D6720*	COMPOSITE RETAINER CROWN - RESIN WITH HIGH NOBLE	\$125*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$0 \$0
	METAL		D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$125*		COLLECTION	
D6722*	BASE METAL RETAINER CROWN - RESIN WITH NOBLE METAL	\$125*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$215*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7310 D7311	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$0 \$0
	HIGH NOBLE METAL		D7311	ALVEOLOPLASTY CONSING XTRCT 1-3 TEETTI	\$0 \$0
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$0
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
20.02	NOBLE METAL	ų.23		(SECONDARY EPITHELIALIZATION)	**
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$125*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	·
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110		ARCH	
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
	1.25 CM		D0054	ARCH	40
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$100	D9951	OCCLUSAL ADJUSTMENT - LIMITED	\$0
D7464	OR TUMOR - LESION DIAMETER UP TO 1.25 CM	¢10E	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$0
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	1.25 CM		D9975	PERFORMED IN OFFICE	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$75	D3313	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	Ψ123
D7472	REMOVAL OF TORUS PALATINUS	\$25	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$25		ENCOUNTER ENCOUNTER	•
D7485	REDUCTION OF OSSEOUS TUBEROSITY	\$25	D9996	TELEDENTISTRY - ASYNCHRONOUS;	\$0
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$15		INFORMATION STORED AND FORWARDED TO	
D7511	I & D ABSCESS - INTRAORAL SOFT TISS	\$15		DENTIST FOR SUBSEQUENT REVIEW	
	COMPLICATED	, -	D9999	BROKEN APPOINTMENT	\$10
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	44.005
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$0	D8090	ADOLESCENT DENTITION	\$1,895
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$15	D0090	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,095
D7961	BUCCAL / LABIAL FRENECTOMY	\$0	D8660	ADULT DENTITION PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
	(FRENULECTOMY)			MONITOR GROWTH AND DEVELOPMENT	V
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$0	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$0		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$25		OF RETAINERS)	
D7971	EXCISION OF PERICORONAL GINGIVA	\$20	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	\$150
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	\$40		FOR REASONS OTHER THAN COMPLETION OF	
ADJUNC	TIVE GENERAL SERVICES		D8999a	TREATMENT	\$150
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$5	Dosssa	a START-UP FEE (INCLUDING EXAM, BEGINNING RECORDS, X-RAYS,TRACING, PHOTOS, AND	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		MODELS)	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0			
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	\$0			
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	\$150			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	\$75			
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	\$30			
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	\$140			
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	\$70			
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	\$50			
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$0			

'Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

'Copays listed are also applicable in the specialist office.

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

'If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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LIMITATIONS OF BENEFITS

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

efit on this Plan's Schedule of Benefits:
Dental Services that are not Necessary.
Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
Any Dental Procedure not directly associated with dental disease.
Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
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.
Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

- 10. 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.
- 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

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:

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

- 1. The following are not Covered orthodontic benefits:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Voluntary 150/covered dental services

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	STIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0405	DISEASES - SPECIMEN ANALYSIS	Φ0
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0473	REPORT	\$0
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC - PREP/REPORT	ΨΟ
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC	\$0	D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG	\$0
	IMAGES			MARG PREP/REPORT	**
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	CARIES RISK ASSESSMENT AND	\$0
D0000	IMAGE	Φ0		DOCUMENTATION, LOW	
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	CARIES RISK ASSESSMENT AND	\$0
D0240	RADIOGRAPHIC IMAGE INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0		DOCUMENTATION, MODERATE	
D0240		\$0 \$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0230	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	φυ		DOCUMENTATION, HIGH	
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0	D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0201	RADIOGRAPHIC IMAGE	Ψ	D	CAPTURE ONLY	•
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE –	\$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	IMAGE CAPTURE ONLY	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	Φ0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0	D0100	IMAGE CAPTURE ONLY	Ψ
DOLIT	IMAGES	Ψ	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0		IMAGE-IMAGE CAPTURE ONLY	
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-	\$0
	ACQUISITION, MEASUREMENT AND ANALYSIS			IMAGE CAPTURE ONLY	
D0364	CONE BEAM CT CAPTURE AND	\$10	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
	INTERPRETATION WITH LIMITED FIELD OF			RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	
	VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$0
D0365	CONE BEAM CT CAPTURE AND	\$10	PREVEN	NTIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D1110 ¹	PROPHYLAXIS - ADULT	\$0
Doocc	OF ONE FULL DENTAL ARCH-MANDIBLE	Ф4 Г	D1110 ¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$15		6 MONTHS	
	INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA		D1120 ¹	PROPHYLAXIS - CHILD	\$0
D0367	CONE BEAM CT CAPTURE AND	\$15	D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
2000.	INTERPRETATION WITH FIELD OF VIEW OF BOTH	4.0	D.1000	MONTHS	•
	JAWS		D1206	TOPICALFLUORIDE VARNISH	\$0
D0368	CONE BEAM CT CAPTURE AND	\$15	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
	INTERPRETATION FOR TMJ SERIES INCLUDING		D4240	EXCLUDING VARNISH	¢0
	TWO OR MORE EXPOSURES		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0 \$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
	SPECIMEN TO INCLUDE CULTURE AND		D1351	SEALANT - PER TOOTH	\$5
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
D0415	TRANSMISSION OF WRITTEN REPORT	¢Λ	D4252	CARIES RISK PATIENT- PERM TOOTH	ሱ F
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0 \$10	D1353	SEALANT REPAIR – PER TOOTH	\$5
D0416	VIRAL CULTURE	\$10	D1355	CARIES PREVENTIVE MEDICAMENT	\$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	\$10		APPLICATION – PER TOOTH	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$125
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$15	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$125
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$15	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$125
D1520	SPACE MAINTAINER -	\$20	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$125
D1526	REMOVABLE-UNILATERAL/QUAD SPACE MAINTAINER - REMOVABLE - BILATERAL,	\$20	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$125
D1527	MAXILLARY SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	\$20	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$125
D1551	RECEM/REBOND BILATERAL SPACE	\$0	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$90
D1552	MAINTAINER – MAXIL RECEM/REBOND BILATERAL SPACE	\$0	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	\$90
	MAINTAINER – MANDIB	**	D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	\$125*
D1553	RECEM/REBOND UNILATERAL SPACE	\$0	D2721	CROWN - RESIN W/PREDOM BASE METAL	\$125*
	MAINTAINER/QUAD		D2722*	CROWN - RESIN WITH NOBLE METAL	\$125*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$10	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$215*
	MAINTAINER/QUAD		D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$125*
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$10	D2751	CROWN - PORCELAIN FUSED PREDOM BASE	\$125*
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$10	D2752*	METAL CROWN - PORCELAIN FUSED NOBLE METAL	\$125*
D1575	MAINTAINER-MANDIB DISTAL SHOE SPACE MAINTAINER – FIXED,	\$15	D2753	CROWN PORCELAIN FUSED TO	\$125
	UNILATERAL/QUAD		D0700*	TITANIUM/TITANIUM ALLOYS	* 405*
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY	\$0	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$125*
DECTOR	REPORT		D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$125*
	ATIVE SERVICES	40	D2782* D2783	CROWN - 3/4 CAST NOBLE METAL CROWN - 3/4 PORCELAIN/CERAMIC	\$125* \$125*
D2140	AMALGAM - ONE SURFACE	\$0	D2703 D2790*	CROWN - 5/4 PORCELAIN/CERAWIC CROWN - FULL CAST HIGH NOBLE METAL	\$125 \$125*
D2150	PRIMARY/PERMANENT AMALGAM - TWO SURFACES	\$0	D2790 D2791	CROWN - FULL CAST PREDOM BASE METAL	\$125*
B2100	PRIMARY/PERMANENT	Ψ	D2791*	CROWN - FULL CAST NOBLE METAL	\$125*
D2160	AMALGAM - 3 SURFACES	\$0	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$125*
D2161	PRIMARY/PERMAMENT AMALGAM - FOUR/MORE SURFACES	\$0	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$0
	PRIMARY/PERMANENT	·	D2915	OR PART COV REST RECEMENT OR RE-BOND INDIRECTLY	\$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0		FABRICATED PREFABRICATED POST & CORE	
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0	D2920	RECEMENT OR RE-BOND CROWN	\$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$20	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$10
D2391 D2392	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$25		PRIMARY	
D2392 D2393	RESIN COMPOSITE - 2 SURFACES POSTERIOR RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$35 \$45	D2931	PREFABRICATED STAINLESS STEEL CROWN -	\$10
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR RESIN COMPOSITE - 4/MORE SURFACES POST	\$45 \$45	D2932	PERMANENT PREFABRICATED RESIN CROWN	\$10
D2534	INLAY - METALLIC - ONE SURFACE	\$115	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$20
D2520	INLAY - METALLIC - TWO SURFACES	\$115		RESIN WINDOW	 -
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$115	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$115		STEEL CROWN - PRIMARY	
D2543	ONLAY - METALLIC THREE SURFACES	\$115	D2940	SEDATIVE FILLING	\$0
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$115	D2941	INTERIM THERAPEUTIC RESTORATION -	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$125*	רטטבט	PRIMARY DENTITION	640
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$125*	D2950	CORE BUILDUP INCLUDING ANY PINS DIN DETENTION DED TOOTH ADDITION DEST	\$10 \$8
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE	\$125*	D2951 D2952	PIN RETENTION - PER TOOTH ADDITION REST	\$8 \$20
	SURFACES		D2952 D2953	POST & CORE ADD CROWN INDIRECT FAB	\$20 \$10
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$125*	DZ3JJ	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	φIU
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$125*	D2954	PREFABRICATED POST & CORE ADDITION	\$10
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$125*		CROWN	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$15		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962		\$600*		MOLAR	
D2902	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	\$000	D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$25	D3911	INTRAORIFICE BARRIER	\$25
DZOTT	XST PART DENTURE	ΨΣΟ	D3920	HEMISECTION NOT INCL RC THERAPY	\$75
D2975	COPING	\$80	D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	\$15
D2980	CROWN REPAIR	\$35	PERIOD	ONTIC SERVICES	
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$50
	SURFACE LESIONS	, ,		TEETH QUAD	
ENDODO	ONTIC SERVICES		D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$35
D3110	PULP CAP - DIRECT	\$0		TEETH QUAD	
D3120	PULP CAP - INDIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D. 40.40	PROC/TOOTH	A =
	JUNC	**	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$115
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$5	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$85
	TEETH		D4245	APICALLY POSITIONED FLAP	\$155
D3222	PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$115
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$5	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$225
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$5	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$155
	TOOTH		D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	ANTERIOR	\$45		NATURAL TOOTH - FIRST SITE IN QUADRANT	
D3320	BICUSPID	\$75	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$75
D3330	MOLAR	\$115		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$65	D 4070	QUADRANT	#405
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$45	D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$195
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$45	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE	\$50
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$70		TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$100		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$140	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$50		TOOTH	
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$45	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$45		TOOTH	
			D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	\$75
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65		PROSTHETIC CROWNS	
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR	\$75
D3357	MEDICAMENT REPLACEMENT	\$65		PROSTHETIC CROWNS	
ונסטטו	PULPAL REGENERATION - COMPLETION OF TREATMENT	φυσ	D4341	PERIODONTAL SCAL & ROOT PLAN	\$25t
D3410	APICOECTOMY SURG - ANT	\$75	D. 40.40	4/>TEETH-QUAD	A. = :
D3421	APICOECTOMY SURG-BICUSPID	\$75	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$15t
D3425	APICOECTOMY SURG - MOLAR	\$75	D4346	SCALING IN PRESENCE OF GENERALIZED	\$15
D3425	APICOECTOMY SURGERY	\$75 \$35		MODERATE OR SEVERE GINGIVAL	
				INFLAMMATION – FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$35 \$35	D4355	EVALUATION	\$25t
D3450	ROOT AMPUTATION - PER ROOT	\$75	D-1000	FULL MOUTH DEBRID COMP ORAL EVAL & DX ON A SUBSEQUENT VISIT	ΨΖΟί
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL	\$55t
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	\$75		AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER	,,,,,
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR	\$75	D4910	TOOTH PERIODONTAL MAINTENANCE	\$15
D3473	SURGICAL REPAIR OF ROOT RESORPTION -	\$75	D4920	UNSCHEDULED DRESSING CHANGE	\$0
B.C=1 :	MOLAR		D4920 D4921	GINGIVAL IRRIGATION PER QUADRANT	\$0 \$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250		ABLE PROSTHODONTIC SERVICES	ΦU
	APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$150*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$15*
D5120	COMPLETE DENTURE - MANDIBULAR	\$150*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$150*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$125*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$150*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$115*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$125*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$115*	DE740	MANDIBULAR	Φ <i>4</i> Γ*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$165*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$45*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$165*	D5711 D5720	REBASE COMPLETE MANDIBULAR DENTURE	\$45*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$45*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$45* \$45*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$45 \$45
	MATERIALS, RESTS AND TEETH)		D5723	RELINE CMPL MAXIL DENTURE (DIRECT)	\$43 \$0*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE –	\$45*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$0*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$0*
D5223	MATERIALS, RESTS AND TEETH)	\$45*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$0*
D0220	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ψ + 3	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$40*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$40*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$40*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$40*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$45*	D5765	SOFT LINER FOR COMPLETE OR PART	\$10
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	Ψισ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$45*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$45*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$325*	D5850	TISSUE CONDITIONING MAXILLARY	\$10
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$325*	D5851	TISSUE CONDITIONING MANDIBULAR	\$10
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$45	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$45	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE	**-**	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$150*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$45
D5283	MAXILLARY	\$150*		DENTURE (PER ARCH)	
D0200	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	Ψ100	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$325	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	***
D5286	REMOVABLE UNILATERAL PARTIAL	\$325	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$0	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$0	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖΙΟ
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$0	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$0		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$15*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$15*		CROWN	
D5520	MAXILLARY	\$15*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	φισ	DCCC	METAL CROWN (HIGH NOBLE METAL)	ФС40
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$15*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$15*	2000.	METAL CROWN (NOBLE METAL)	Ų000
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$15*		(HIGH NOBLE METAL)	
DEC00	MANDIBULAR	* 4.5*	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$15*	B 222 ***	(PREDOMINATELY BASE METAL)	4-4-
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$15*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
_0000	TOOTH	Ψισ	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$15*	50003	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	φυσυ
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$15*		55	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)			DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	,
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH -	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	·
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40	D0404	TO TITANIUM/TITANIUM ALLOYS	***
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	φοσο
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	,	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$125*
D0000	ALLOYS	ψονο	D6211	PONTIC - CAST PREDOM BASE METAL	\$125*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$125*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$125*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$125*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$125*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$125*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$125*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	A
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$215*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$125*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$125*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$125*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED P	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$125*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$125*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	DC700*	BASE METAL	¢40Γ*
D6E49	PROSTHESIS	¢200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$125* \$175*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$175* \$125*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	\$125*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$145*		RETAINER CROWN - FULL CAST HIGH NOBLE METAL	·
D6601	SURFACES	\$145*	D6791	RETAINER CROWN - FULL CAST	\$125*
D0001	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	ψ143	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$125*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2	\$115*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$125*
D6603*	SURFACES RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$115*	DC000	ALLOYS	фол
D0000	SURFACES	ΨΠΟ	D6920 D6930	CONNECTOR BAR	\$85 \$0
D6604	RETAINER INLAY - CAST PREDOM BASE METAL	\$115*		RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	•
D6605	2 SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$115*	D6940	STRESS BREAKER	\$110
	3/>SURFACES	****	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT URGERY SERVICES	\$60
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$115*	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$0
D6607*	SURFACES	\$115*	D7111	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$0 \$0
D0001	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	\$115	D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$15
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$155*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC	\$155*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$25
D6610*	3/MORE SURFACES RETAINER ONLAY - CAST HI NOBLE METAL 2	\$115*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$50
	SURFACES		D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$75
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$115*	D7241	BONY	\$90
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL	\$150*		REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	·
D6613	2 SURFACES	\$150*	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS	\$0
D0013	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$150	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$115*		REMOVAL	
DCC4E*	SURFACES	044 5 *	D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	\$115*	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$50
D6624*	RETAINER INLAY - TITANIUM	\$125*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634*	RETAINER ONLAY - TITANIUM	\$125*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$85
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$0
D6720*	COMPOSITE RETAINER CROWN - RESIN WITH HIGH NOBLE	\$125*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$0 \$0
	METAL		D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$125*		COLLECTION	
D6722*	BASE METAL RETAINER CROWN - RESIN WITH NOBLE METAL	\$125*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$215*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7310 D7311	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$0 \$0
	HIGH NOBLE METAL		D7311	ALVEOLOPLASTY CONSING XTRCT 1-3 TEETTI	\$0 \$0
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$0
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
20.02	NOBLE METAL	ų.23		(SECONDARY EPITHELIALIZATION)	**
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$125*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	\$05
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$0
D1400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$0
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
	1.25 CM		D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$75		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$25	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$25	D9996	ENCOUNTER TELEPENTISTRY ASYMCHRONOLIS	\$0
D7485 D7510	REDUCTION OF OSSEOUS TUBEROSITY	\$25 \$15	D3330	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	ΨΟ
D7510 D7511	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$15 \$15		DENTIST FOR SUBSEQUENT REVIEW	
וונוע	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	φισ	D9999	BROKEN APPOINTMENT	\$10
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$0	D8090	ADOLESCENT DENTITION	\$1,895
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$15	D0090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	φ1,033
D7961	BUCCAL / LABIAL FRENECTOMY	\$0	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
D-7000	(FRENULECTOMY)	00		MONITOR GROWTH AND DEVELOPMENT	
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$0 \$0	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$0 \$35		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970 D7971	EXC HYPERPLASTIC TISSUE-PER ARCH EXCISION OF PERICORONAL GINGIVA	\$25 \$20	DOCOL	OF RETAINERS)	\$450
D7971	SURGICAL RDUC FIBROUS TUBEROSITY	\$20 \$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF	\$150
	TIVE GENERAL SERVICES	φ40		TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$5	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
	ANESTHESIA				
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
D0000	15 MINUTES	A7 5			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
D9230	15 MINUTE INCREMENT ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
20200	NITROUS OXIDE	400			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
	SEDATION/ANESTHESIA - FIRST 15 MINUTES				
D9243	INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
	SEDATION/ANALGESIA - EACH 15 MINUTE				
D9248	INCREMENT NON-INTRAVENOUS (CONSCIOUS) SEDATION,	\$50			
	THIS INCLUDES NON-IV MINIMAL AND	***			
	MODERATE SEDATION				
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$0			

'Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

*Copays listed are also applicable in the specialist office.

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

*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

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LIMITATIONS OF BENEFITS

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
10.	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.

- Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

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:

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

- 1. The following are not Covered orthodontic benefits:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

UnitedHealthcare® DHMO/Contributory 150C/covered dental services

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
DIAGNO	OSTIC SERVICES		D0418	ANALYSIS OF SALIVA SAMPLE	\$10
D0120	PERIODIC ORAL EVALUATION EST PT	\$0	D0422	COLLECTION AND PREPARATION OF GENETIC	\$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	\$0		SAMPLE MATERIAL FOR LABORATORY	
D0145	ORAL EVAL PT<3 AND COUNSEL	\$0		ANALYSIS AND REPORT	
D0150	COMP ORAL EVALUATION - NEW/EST PT	\$0	D0423	GENETIC TEST FOR SUSCEPTIBILITY TO	\$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS	\$0	D0405	DISEASES - SPECIMEN ANALYSIS	Φ0
	REPORT		D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0	D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$20
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE	\$5	D0460	PULP VITALITY TESTS	\$0
	VISIT		D0470	DIAGNOSTIC CASTS	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0	D0472	ACCESS TISSUE, GROSS EXAM - PREP &	\$0
D0190	SCREENING OF A PATIENT	\$5	D0470	REPORT	Φ0
D0191	ASSESMENT OF A PATIENT	\$5	D0473	ACCESS TISSUE, GROSS & MICROSCOPIC -	\$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC IMAGES	\$0	D0474	PREP/REPORT ACCESS TISSUE, GROSS & MICROSCOPIC SURG	\$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC	\$0	D0601	MARG PREP/REPORT	\$0
	IMAGE		D0601	CARIES RISK ASSESSMENT AND	\$0
D0230	INTRAORL PERIAPICAL EACH ADD	\$0	D0602	DOCUMENTATION, LOW	\$0
	RADIOGRAPHIC IMAGE		D0002	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	ΨΟ
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0	D0603	CARIES RISK ASSESSMENT AND	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC	\$0	20000	DOCUMENTATION, HIGH	ų.
	IMAGE		D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE	\$0
D0251	EXTRA-ORAL POSTERIOR DENTAL	\$0		CAPTURE ONLY	
D.00	RADIOGRAPHIC IMAGE	**	D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE –	\$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0		IMAGE CAPTURE ONLY	
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0	D0705	EXTRA-ORAL POSTERIOR DENTAL	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0		RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0	D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC	\$0		IMAGE CAPTURE ONLY	•
D0000	IMAGES	Φ0	D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0	D0708	IMAGE-IMAGE CAPTURE ONLY	\$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE -	\$0	D0700	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE- IMAGE CAPTURE ONLY	ΨΟ
D0364	ACQUISITION, MEASUREMENT AND ANALYSIS	\$10	D0709	INTRAORAL-COMPLETE SERIES OF	\$0
D0304	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF	ΨΙΟ		RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	•
	VIEW-LESS THAN ONE WHOLE JAW		D0999	OFFICE VISIT FEE - PER VISIT	\$5
D0365	CONE BEAM CT CAPTURE AND	\$10	PREVEN	ITIVE SERVICES	
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11101	PROPHYLAXIS - ADULT	\$0
	OF ONE FULL DENTAL ARCH-MANDIBLE		D1110¹	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN	\$25
D0366	CONE BEAM CT CAPTURE AND	\$15	20	6 MONTHS	42 5
	INTERPRETATION WITH LIMITED FIELD OF VIEW		D11201	PROPHYLAXIS - CHILD	\$0
	OF ONE FULL DENTAL ARCH-MAXILLA		D11201	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6	\$25
D0367	CONE BEAM CT CAPTURE AND	\$15		MONTHS	
	INTERPRETATION WITH FIELD OF VIEW OF BOTH		D1206	TOPICALFLUORIDE VARNISH	\$0
DU360	JAWS	\$15	D1208	TOPICAL APPLICATION OF FLUORIDE -	\$0
D0368	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING	Φ1 3		EXCLUDING VARNISH	
	TWO OR MORE EXPOSURES		D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5	D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	\$0
D0414	LABORATORY PROCESSING OF MICROBIAL	\$0	D1330	ORAL HYGIENE INSTRUCTIONS	\$0
	SPECIMEN TO INCLUDE CULTURE AND	+3	D1351	SEALANT - PER TOOTH	\$5
	SENSITIVITY STUDIES, PREPARATION AND		D1352	PREV RESIN RESTORATION IN MOD HIGH	\$10
	TRANSMISSION OF WRITTEN REPORT			CARIES RISK PATIENT- PERM TOOTH	
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0	D1353	SEALANT REPAIR - PER TOOTH	\$5
D0446	VIDAL OURTURE	A 40			4.5

\$10

\$10

D1355

CARIES PREVENTIVE MEDICAMENT

APPLICATION - PER TOOTH

D0417

D0416 VIRAL CULTURE

COLLECTION & PREP OF SALIVA SAMPLE

\$0

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
PREVEN	TIVE SERVICES		D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	\$125
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	\$15	D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	\$125
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	\$15	D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	\$125
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	\$20	D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	\$125
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	\$20	D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	\$125
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL,	\$20	D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	\$125
D1551	MANDIBULAR RECEM/REBOND BILATERAL SPACE	\$0	D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	\$90
D1552	MAINTAINER – MAXIL RECEM/REBOND BILATERAL SPACE	\$0	D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	\$90
	MAINTAINER – MANDIB		D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	\$125*
D1553	RECEM/REBOND UNILATERAL SPACE	\$0	D2721	CROWN - RESIN W/PREDOM BASE METAL	\$125*
	MAINTAINER/QUAD		D2722*	CROWN - RESIN WITH NOBLE METAL	\$125*
D1556	REMOVAL OF FIXED UNILATERAL SPACE	\$10	D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$215*
D4557	MAINTAINER/QUAD	¢ 40	D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	\$125*
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	\$10	D2751	CROWN - PORCELAIN FUSED PREDOM BASE METAL	\$125*
D1558	REMOVAL OF FIXED BILATERAL SPACE	\$10	D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$125*
D1575	MAINTAINER-MANDIB DISTAL SHOE SPACE MAINTAINER – FIXED,	\$15	D2753	CROWN PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$125
D1999	UNILATERAL/QUAD	\$5	D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$125*
ופפפוט	UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT	φυ	D2781	CROWN - 3/4 CAST PREDOM BASE METAL	\$125*
RESTOR	ATIVE SERVICES		D2782*	CROWN - 3/4 CAST NOBLE METAL	\$125*
D2140		\$0	D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$125*
D2140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	ΨΟ	D2790*	CROWN - FULL CAST HIGH NOBLE METAL	\$125*
D2150	AMALGAM - TWO SURFACES	\$0	D2791	CROWN - FULL CAST PREDOM BASE METAL	\$125*
	PRIMARY/PERMANENT		D2792*	CROWN - FULL CAST NOBLE METAL	\$125*
D2160	AMALGAM - 3 SURFACES	\$0	D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	\$125*
D2161	PRIMARY/PERMAMENT AMALGAM - FOUR/MORE SURFACES	\$0	D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER	\$0
D2330	PRIMARY/PERMANENT RESIN COMPOSITE - ONE SURFACE ANTERIOR	\$0	D2915	112021112111 011112 00110 111011120121	\$0
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	\$0	D0000	FABRICATED PREFABRICATED POST & CORE	40
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	\$0	D2920	RECEMENT OR RE-BOND CROWN	\$0
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	\$0	D2921	REATTACHMENT OF TOOTH FRAGMENT	\$65
D2390	RESIN COMPOSITE CROWN ANTERIOR	\$20	D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$80*
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	\$25	D2930	PREFABRICATED STAINLESS STEEL CROWN -	\$10
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	\$35	D2931	PRIMARY	\$10
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	\$45	D2301	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	Ψίο
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	\$45	D2932	PREFABRICATED RESIN CROWN	\$10
D2510	INLAY - METALLIC - ONE SURFACE	\$115	D2933	PREFABRICATED STAINLESS STEEL CROWN	\$20
D2520	INLAY - METALLIC - TWO SURFACES	\$115		RESIN WINDOW	
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$115	D2934	PREFABRICATED ESTHTC COATED STNLESS	\$60
D2542	ONLAY - METALLIC - TWO SURFACES	\$115		STEEL CROWN - PRIMARY	
D2543	ONLAY - METALLIC THREE SURFACES	\$115	D2940	SEDATIVE FILLING	\$0
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	\$115	D2941	INTERIM THERAPEUTIC RESTORATION -	\$5
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	\$125*		PRIMARY DENTITION	
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$125*	D2950	CORE BUILDUP INCLUDING ANY PINS	\$10
D2630		\$125*	D2951	PIN RETENTION - PER TOOTH ADDITION REST	\$8
DZ000	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	۷۱۲۷	D2952	POST & CORE ADD CROWN INDIRECT FAB	\$20
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	\$125*	D2953	EACH ADD INDIRECT FABRICATED POST SAME	\$10
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	\$125*	D00=1	ТООТН	*
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE	\$125*	D2954	PREFABRICATED POST & CORE ADDITION CROWN	\$10

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
RESTOR	ATIVE SERVICES		D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2955	POST REMOVAL	\$10		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2957	EACH ADD PREFABR POST - SAME TOOTH	\$15		PREMOLAR	
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	\$295	D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	\$350*		APICOECTOMY OR REPAIR OF ROOT RESORPT-	
D2962	LABIAL VENEER (PORCELAIN LAMINATE) -	\$600*	D3910	MOLAR SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$15
	INDIRECT		D3910 D3911	INTRAORIFICE BARRIER	\$15 \$25
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER	\$25	D3911	HEMISECTION NOT INCL RC THERAPY	\$25 \$75
	XST PART DENTURE		D3920		\$15
D2975	COPING	\$80		CANAL PREP & FIT PREFORMED DOWEL/POST ONTIC SERVICES	\$10
D2980	CROWN REPAIR	\$35			¢E0
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH	\$5	D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG	\$50
ENDODO	SURFACE LESIONS		D4211	TEETH QUAD GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG	\$35
	ONTIC SERVICES		51211	TEETH QUAD	400
D3110	PULP CAP - DIRECT	\$0	D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST	\$15
D3120	PULP CAP - INDIRECT	\$0		PROC/TOOTH	
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL	\$0	D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$115
D3221	JUNC	¢E	D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	\$85
D3ZZT	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT	\$5	D4245	APICALLY POSITIONED FLAP	\$155
D3222	TEETH PARTIAL PULPOTOMY	\$60	D4249	CLIN CROWN LEN - HARD TISSUE	\$115
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	\$5	D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$225
D3240	PULPAL THERAPY - POSTERIOR PRIMARY	\$5	D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$155
50210	TOOTH	40	D4263	BONE REPLACEMENT GRAFT – RETAINED	\$175
D3310	ANTERIOR	\$45		NATURAL TOOTH – FIRST SITE IN QUADRANT	
D3320	BICUSPID	\$75	D4264	BONE REPLACEMENT GRAFT – RETAINED	\$75
D3330	MOLAR	\$115		NATURAL TOOTH – EACH ADDITIONAL SITE IN	
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$65	D4270	QUADRANT	¢105
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$45	D4270 D4274	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$195 \$50
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$45	D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN	\$50
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$70		CONJUNCTION WITH SURGICAL PROCEDURES	
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$100		IN THE SAME ANATOMICAL AREA)	
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$140	D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST	\$235
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	\$50		ТООТН	
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	\$45	D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD	\$275
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$45		TOOTH	
D3355	PULPAL REGENERATION - INITIAL VISIT	\$65	D4322	SPLINT-INTRA-CORONAL; NATURAL TEETH OR	\$75
D3356	PULPAL REGENERATION - INTERIM	\$65	D4323	PROSTHETIC CROWNS	\$75
	MEDICAMENT REPLACEMENT		D4323	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	Ψ13
D3357	PULPAL REGENERATION - COMPLETION OF	\$65	D4341	PERIODONTAL SCAL & ROOT PLAN	\$25t
	TREATMENT		2.0	4/>TEETH-QUAD	420 .
D3410	APICOECTOMY SURG - ANT	\$75	D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	\$15t
D3421	APICOECTOMY SURG-BICUSPID	\$75	D4346	SCALING IN PRESENCE OF GENERALIZED	\$15
D3425	APICOECTOMY SURG - MOLAR	\$75		MODERATE OR SEVERE GINGIVAL	
D3426	APICOECTOMY SURGERY	\$35		INFLAMMATION - FULL MOUTH, AFTER ORAL	
D3430	RETROGRADE FILLING - PER ROOT	\$35		EVALUATION	**-:
D3450	ROOT AMPUTATION - PER ROOT	\$75	D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX	\$25t
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$900	D/301	ON A SUBSEQUENT VISIT	¢££+
D3471	SURGICAL REPAIR OF ROOT RESORPTION -	\$75	D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL	\$55t
	ANTERIOR			AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER	
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	\$75		TOOTH	
D3473	PREMOLAR	ሱ ጋ ር	D4910	PERIODONTAL MAINTENANCE	\$15
D3473	SURGICAL REPAIR OF ROOT RESORPTION –	\$75	D4920	UNSCHEDULED DRESSING CHANGE	\$0
D3501	MOLAR SURGICAL EXPOSURE ROOT SURFACE W/OUT	\$250	D4921	GINGIVAL IRRIGATION I PER QUADRANT	\$0
_ 5551	APICOECTOMY OR REPAIR ROOT	\$200	REMOV	ABLE PROSTHODONTIC SERVICES	
	RESORPT-ANTERIOR		D5110	COMPLETE DENTURE - MAXILLARY	\$150*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
REMOVA	ABLE PROSTHODONTIC SERVICES		D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER	\$15*
D5120	COMPLETE DENTURE - MANDIBULAR	\$150*		TOOTH	
D5130	IMMEDIATE DENTURE - MAXILLARY	\$150*	D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$125*
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$150*		MAXILLARY	
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$115*	D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK	\$125*
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$115*	DE740	MANDIBULAR	Φ <i>4</i> Γ*
D5213	MAX PART DENTUR-CAST METL W/RSN	\$165*	D5710	REBASE COMPLETE MAXILLARY DENTURE	\$45*
D5214	MAND PART DENTUR- CAST METL W/RSN	\$165*	D5711 D5720	REBASE COMPLETE MANDIBULAR DENTURE	\$45*
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE –	\$45*	D5720 D5721	REBASE MAXILLARY PARTIAL DENTURE REBASE MANDIBULAR PARTIAL DENTURE	\$45* \$45*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5721	REBASE HYBRID PROSTHESIS	\$45 \$45
	MATERIALS, RESTS AND TEETH)		D5723	RELINE CMPL MAXIL DENTURE (DIRECT)	\$0*
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$45*	D5730	RELINE CMPL MAND DENTURE (DIRECT)	\$0*
	RESIN BASE (INCLUDING RETENTIVE/CLASPING		D5731	RELINE MAXIL PART DENTURE (DIRECT)	\$0*
D5223	MATERIALS, RESTS AND TEETH)	\$45*	D5740	RELINE MAND PART DENTURE (DIRECT)	\$0*
D0220	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN	ψ + 3	D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	\$40*
	DENTURE BASES (INCLUDING		D5750	RELINE CMPL MAND DENTURE (INDIRECT)	\$40*
	RETENTIVE/CLASPING MATERIALS, RESTS AND		D5760	RELINE MAXIL PART DENTURE (INDIRECT)	\$40*
	TEETH)		D5761	RELINE MAND PART DENTURE (INDIRECT)	\$40*
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE -	\$45*	D5765	SOFT LINER FOR COMPLETE OR PART	\$10
	CAST METAL FRAMEWORK WITH RESIN		D0100	REMOVABLE DENTURE-INDIRECT	Ψισ
	DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND		D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$45*
	TEETH)		D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$45*
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$325*	D5850	TISSUE CONDITIONING MAXILLARY	\$10
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	\$325*	D5851	TISSUE CONDITIONING MANDIBULAR	\$10
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX	\$45	D5863	OVERDENTURE - COMPLETE MAXILLARY	\$425
	BASE		D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$450
D5228	IMMEDIATE MANDIBULAR PARTIAL	\$45	D5865	OVERDENTURE - PARTIAL MAXILLARY	\$425
	DENTURE-FLEX BASE	**-**	D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$450
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE -	\$150*	D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL	\$45
D5283	MAXILLARY	\$150*		DENTURE (PER ARCH)	
D0200	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	Ψ100	IMPLAN'	T SERVICES	
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE –	\$325	D6010	SURGICAL PLACEMENT OF IMPLANT BODY:	\$975
	FLEX BASE/QUAD		D0040	ENDOSTEAL IMPLANT	***
D5286	REMOVABLE UNILATERAL PARTIAL	\$325	D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$825
	DENTURE-RESIN/QUAD		D6055	DENTAL IMPLANT SUPPORTED CONNECTING	\$930
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$0	D6056	BAR	\$275
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$0	D0030	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	ΨΖΙΟ
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$0	D6057	CUSTOM FAB ABUTMENT - INCLUDES	\$385
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$0		PLACEMENT	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	\$15*	D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC	\$680
D5512	REPAIR BROKEN COMPLETE DENTURE BASE -	\$15*		CROWN	
D5520	MAXILLARY	\$15*	D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$670
D3320	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	φισ	DCCC	METAL CROWN (HIGH NOBLE METAL)	ФС40
D5611	REPAIR RESIN PARTIAL DENTURE BASE -	\$15*	D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$610
	MANDIBULAR		D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO	\$585
D5612	REPAIR RESIN PARTIAL DENTURE BASE -	\$15*	2000.	METAL CROWN (NOBLE METAL)	Ų000
	MAXILLARY		D6062*	ABUTMENT SUPPORTED CAST METAL CROWN	\$665
D5621	REPAIR CAST PARTIAL FRAMEWORK -	\$15*		(HIGH NOBLE METAL)	
DEC00	MANDIBULAR	* 4.5*	D6063	ABUTMENT SUPPORTED CAST METAL CROWN	\$580
D5622	REPAIR CAST PARTIAL FRAMEWORK -	\$15*	B 222 ***	(PREDOMINATELY BASE METAL)	4-4-
D5630	MAXILLARY REPAIR OR REPLACE BROKEN CLASP - PER	\$15*	D6064*	ABUTMENT SUPPORTED CAST METAL CROWN	\$585
_0000	TOOTH	Ψισ	D6065	(NOBLE METAL)	\$690
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$15*	50003	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	φυσυ
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$15*		55	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
IMPLANT	SERVICES		D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	\$10
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	\$660	D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	\$670
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	\$670	D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	\$680
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$655	D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	\$680
D6069	ABUTMENT SUPPORTED RETAINER FOR	\$660	D6100	SURGICAL REMOVAL OF IMPLANT BODY	\$260
	PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	,,,,,	D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR	\$240
D6070	ABUTMENT SUPPORTED RETAINER FOR	\$630	D6102	DEFECTS SURROUNDING A SINGLE IMPLANT DEBRIDEMENT & OSSEOUS PERI IMPLANT	\$275
	PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)			DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	,
D6071*	ABUTMENT SUPPORTED RETAINER FOR	\$645	D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT	\$245
	PORCELAIN FUSED TO METAL FPD (NOBLE			DEFECT	
D0070*	METAL)	4005	D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE	\$875
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$635		DENTURE FOR EDENTULOUS ARCH -	
D6073	METAL FPD (HIGH NOBLE METAL)	\$595	DC444	MAXILLARY	07 7
D0073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	φυσυ	D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST	\$630		DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	
	METAL FPD (NOBLE METAL)	,,,,,	D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$615		DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	·
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD -	\$680	D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE	\$875
	PORCELAIN FUSED TO HIGH NOBLE ALLOYS			DENTURE FOR PARTIALLY EDENTULOUS ARCH	
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL	\$630		- MANDIBULAR	
	FPD - HIGH NOBLE ALLOYS		D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED	\$680
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN	\$40	D0404	TO TITANIUM/TITANIUM ALLOYS	***
	PROSTHESIS ARE REMOVED AND REINSERTED,		D6121	IMPLANT SUPPT RETAINER FOR METAL	\$630
	INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS		D6122	FPD-PREDOM. BASE ALLOYS	\$630
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE	\$180t	D0122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	φοσο
	OF INFLAMMATION OR MUCOSITIS OF A SINGLE	,	D6123	IMPLANT SUPPT RETAINER FOR METAL	\$630
	IMPLANT, INCLUDING CLEANING OF THE			FPD-TITANIUM/TITANIUM ALLOYS	
	IMPLANT SURFACES, WITHOUT FLAP ENTRY		D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY	\$145
D.0000	AND CLOSURE	***		REPORT	
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	\$220
D6083	PREDOM. BASE ALLOYS	\$660	D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	\$220
	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS		D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	\$545
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO	\$660	D6195	ABUTMENT SUPPT RETAINER-PORCELAIN	\$660
Dense	TITANIUM/TITANIUM ALLOYS	¢670		FUSED TO TITANIUM/TITANIUM ALLOYS	
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE	\$670	FIXED P	ROSTHODONTIC SERVICES	
D6087	ALLOYS IMPLANT SUPPT CROWN-NOBLE ALLOYS	\$670	D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$250
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM	\$670	D6210*	PONTIC - CAST HIGH NOBLE METAL	\$125*
D0000	ALLOYS	ψονο	D6211	PONTIC - CAST PREDOM BASE METAL	\$125*
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY	\$165	D6212*	PONTIC - CAST NOBLE METAL	\$125*
	REPORT		D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	\$125*
D6091	REPLCMT OF REPLCEABLE PART OF	\$90	D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	\$125*
	SEMI-PRECISION/PRECISION ATTCHMT OF		D6241	PONTIC - PORCELAIN FUSED PREDOM BASE	\$125*
	IMPLANT/ABUTMENT SUPPT PROSTHESIS, PER			METAL	
DC000	ATTCHMT	# C0	D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	\$125*
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$60	D6243	PONTIC-PORCELAIN FUSED TO	\$125*
D6093	SUPPORTED CROWN RECEMENT OR RE-BOND IMPLANT/ABUTMENT	\$70	B 00 :=	TITANIUM/TITANIUM ALLOYS	A
20000	SUPPORTED FIXED PARTIAL DENTURE	ΨιΟ	D6245	PONTIC - PORCELAIN/CERAMIC	\$215*
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$530	D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$125*
	AND TITANIUM ALLOYS		D6251	PONTIC RESIN W/PREDOM BASE METAL	\$125*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$215	D6252*	PONTIC RESIN W/NOBLE METAL	\$125*

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
FIXED P	ROSTHODONTIC SERVICES		D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE	\$125*
D6253	INTERIM PONTIC-FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	\$160	D6781	METAL RETAINER CROWN - 3/4 CAST PREDOMINANTLY	\$125*
D6545	RETAINER - CASE METAL FOR RESIN FIXED	\$250	DC700*	BASE METAL	¢40Γ*
D6E49	PROSTHESIS	¢200*	D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$125* \$175*
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	\$300*	D6783 D6784	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$175* \$125*
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	\$85	D6790*	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	\$125*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2	\$145*		RETAINER CROWN - FULL CAST HIGH NOBLE METAL	·
D6601	SURFACES	\$145*	D6791	RETAINER CROWN - FULL CAST	\$125*
D0001	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	ψ143	D6792*	PREDOMINANTLY BASE METAL RETAINER CROWN - FULL CAST NOBLE METAL	\$125*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2	\$115*	D6794*	RETAINER CROWN - TITANIUM AND TITANIUM	\$125*
D6603*	SURFACES RETAINER INLAY - CAST HI NOBLE METAL 3/>	\$115*	DC000	ALLOYS	фол
D0000	SURFACES	ΨΠΟ	D6920 D6930	CONNECTOR BAR	\$85 \$0
D6604	RETAINER INLAY - CAST PREDOM BASE METAL	\$115*		RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	•
D6605	2 SURFACES RETAINER INLAY - CAST PREDOM BASE METAL	\$115*	D6940	STRESS BREAKER	\$110
	3/>SURFACES	****	D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT URGERY SERVICES	\$60
D6606*	RETAINER INLAY - CAST NOBLE METAL 2	\$115*	D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	\$0
D6607*	SURFACES	\$115*	D7111	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$0 \$0
D0001	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	\$115	D7210	EXTRACTION, ERUPTED TOOTH REQUIRING	\$15
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	\$155*		REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF	
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC	\$155*	D7220	MUCOPERIOSTEAL FLAP IF INDICATED REMOVAL IMPACT TOOTH - SOFT TISSUE	\$25
D6610*	3/MORE SURFACES RETAINER ONLAY - CAST HI NOBLE METAL 2	\$115*	D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$50
	SURFACES		D7240	REMOVAL IMPACTED TOOTH - COMPLETELY	\$75
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	\$115*	D7241	BONY	\$90
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL	\$150*		REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	·
D6613	2 SURFACES	\$150*	D7250	REMOVAL OF RESIDUAL TOOTH ROOTS	\$0
D0013	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	\$150	D7251	(CUTTING PROCEDURE) CORONECTOMY - INTENTIONAL PARTIAL TOOTH	\$150
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2	\$115*		REMOVAL	
DCC4E*	SURFACES	044 5 *	D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$225
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	\$115*	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	\$50
D6624*	RETAINER INLAY - TITANIUM	\$125*	D7280	EXPOSURE OF AN UNERUPTED TOOTH	\$85
D6634*	RETAINER ONLAY - TITANIUM	\$125*	D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED	\$85
D6710	RETAINER CROWN - INDIRECT RESIN BASED	\$185*	D7285	TOOTH TO AID ERUPTION INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$0
D6720*	COMPOSITE RETAINER CROWN - RESIN WITH HIGH NOBLE	\$125*	D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$0 \$0
	METAL		D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE	\$20
D6721	RETAINER CROWN - RESIN PREDOMINANTLY	\$125*		COLLECTION	
D6722*	BASE METAL RETAINER CROWN - RESIN WITH NOBLE METAL	\$125*	D7288	BRUSH BIOPSY	\$20
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$215*	D7290	SURGICAL REPOSITIONING OF TEETH	\$75
D6750*	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7310 D7311	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	\$0 \$0
	HIGH NOBLE METAL		D7311	ALVEOLOPLASTY CONSING XTRCT 1-3 TEETTI	\$0 \$0
D6751	RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	\$0
D6752*	PREDOMINANTLY BASE METAL RETAINER CROWN - PORCELAIN FUSED TO	\$125*	D7340	VESTIBULOPLASTY - RIDGE EXTENSION	\$215
20.02	NOBLE METAL	ų.23		(SECONDARY EPITHELIALIZATION)	**
D6753	RETAINER CROWN-PORCELAIN FUSED TO	\$125*	D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$670
	TITANIUM/TITANIUM ALLOYS			(INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	

ADA	DESCRIPTION	MEMBER PAYS	ADA	DESCRIPTION	MEMBER PAYS
ORAL SI	JRGERY SERVICES		D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL	\$85
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$70		ARCH	
	TUMOR - LESION DIAMETER UP TO 1.25 CM		D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL	\$85
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR	\$110	D0040	ARCH	\$05
	TUMOR - LESION DIAMETER GREATER THAN		D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL	\$85
D7460	1.25 CM	\$100	D9951	ARCH OCCLUSAL ADJUSTMENT - LIMITED	\$0
D1400	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	Ψ100	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$0
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST	\$125	D9972	EXTERNAL BLEACHING - PER ARCH	\$125
	OR TUMOR - LESION DIAMETER GREATER THAN			PERFORMED IN OFFICE	
	1.25 CM		D9975	EXTERNAL BLEACHING FOR HOME	\$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$75		APPLICATION, PER ARCH	
D7472	REMOVAL OF TORUS PALATINUS	\$25	D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME	\$0
D7473	REMOVAL OF TORUS MANDIBULARIS	\$25	D9996	ENCOUNTER TELEPENTISTRY ASYMCHRONOLIS	\$0
D7485 D7510	REDUCTION OF OSSEOUS TUBEROSITY	\$25 \$15	D3330	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO	ΨΟ
D7510 D7511	I & D ABSCESS - INTRAORAL SOFT TISSUE	\$15 \$15		DENTIST FOR SUBSEQUENT REVIEW	
וונוע	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	φισ	D9999	BROKEN APPOINTMENT	\$10
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$70	ORTHO	DONTIC SERVICES	
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$190	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7530	REMOVAL OF FOREIGN BODY - SKIN	\$40		TRANSITIONAL DENTITION)	
	SUBCUTANEOUS		D8080	COMPREHENSIVE ORTHODONTIC TREATMENT	\$1,895
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	\$0	D8090	ADOLESCENT DENTITION	\$1,895
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$15	D0090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	φ1,033
D7961	BUCCAL / LABIAL FRENECTOMY	\$0	D8660	PRE-ORTHODONTIC TREATMENT EXAM TO	\$250
D-7000	(FRENULECTOMY)	00		MONITOR GROWTH AND DEVELOPMENT	
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	\$0 \$0	D8680	ORTHODONTIC RETENTION (REMOVAL OF	\$300
D7963	FRENULOPLASTY	\$0 \$35		APPLIANCES, CONSTRUCTION AND PLACEMENT	
D7970 D7971	EXC HYPERPLASTIC TISSUE-PER ARCH EXCISION OF PERICORONAL GINGIVA	\$25 \$20	DOCOL	OF RETAINERS)	\$450
D7971	SURGICAL RDUC FIBROUS TUBEROSITY	\$20 \$40	D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF	\$150
	TIVE GENERAL SERVICES	φ40		TREATMENT	
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$5	D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING	\$150
D9211	REGIONAL BLOCK ANESTHESIA	\$0		RECORDS, X-RAYS, TRACING, PHOTOS, AND	
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0		MODELS)	
D9215	LOCAL ANESTHESIA	\$0			
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL	\$0			
	ANESTHESIA				
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST	\$150			
D0000	15 MINUTES	A7 5			
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH	\$75			
D9230	15 MINUTE INCREMENT ANALGESIA ANXIOLYSIS, INHALATION OF	\$30			
20200	NITROUS OXIDE	400			
D9239	INTRAVENOUS MODERATE (CONSCIOUS)	\$140			
	SEDATION/ANESTHESIA - FIRST 15 MINUTES				
D9243	INTRAVENOUS MODERATE (CONSCIOUS)	\$70			
	SEDATION/ANALGESIA - EACH 15 MINUTE				
D9248	INCREMENT NON-INTRAVENOUS (CONSCIOUS) SEDATION,	\$50			
	THIS INCLUDES NON-IV MINIMAL AND	***			
	MODERATE SEDATION				
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0			
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$5			
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$35			
D9450	CASE PRSATION DTL & EXT TX PLANNING	\$0			
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0			
D9943	OCCLUSAL GUARD ADJUSTMENT	\$0			

¹Additional Prophy within 6 months will be based upon the necessity recommended by the provider.
²Copays listed are also applicable in the specialist office.
For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.
*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed \$150 per unit. If a base metal is used, there are no additional charges from the provider.

LIMITATIONS OF BENEFITS

4	PERIODIC ORAL EVALUATION	Limited to 1 time per 6 months
1.		•
2.	COMPLETE SERIES OR PANOREX RADIOGRAPHS	Limited to 1 time in any 2 year period
3.	BITEWING RADIOGRAPHS DENTAL PROPHYLAXIS	Limited to 1 series of 4 films in any 6 month period Limited to 1 time per 6 months
4.		•
5.	FLUORIDE TREATMENTS	Limited to one time per calendar year
6.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7.	POST AND CORES	Covered only for teeth that have had root canal therapy.
8.	SCALING AND ROOT PLANING PERIODONTAL MAINTENANCE	Limited to 4 quadrants per calendar year.
9.		Limited to once every 6 months, following active therapy, exclusive of gross debridement
10.	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 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.
11.	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.
12.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.		Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
15.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16.	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.
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 lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and(B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred
		• In order for specialty services to be Covered by this plan, the following referral process must be followed:
		A Covered Person's PCD must coordinate all Dental Services.
		• When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization
		• If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
		• Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
		Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

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

21.	CROWNS, FIXED BRIDGES, AND	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial
	IMPLANTS	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.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

ben	efit 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
10.	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.

 11. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
- 12. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- 14. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.
- 15. 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.
- 16. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- 17. 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.
- 18. 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.
- 19. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- 20. 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.

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:

21 Orthodontic Exclusions and 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 member will be responsible for all costs associated with any orthodontic treatment.

- 1. The following are not Covered orthodontic benefits:
- 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 accident
- · Palatal expansion appliances
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
- 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.
- 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
- 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
- 5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
- 22. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization