Welcome to your dental plan.

PALM BEACH COUNTY FireFighters EMPLOYEE BENEFITS FUND

United Healthcare®

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Open enrollment

Dental plan details are here.

Use this guide to review dental benefits from UnitedHealthcare. Inside, you can check out plan details, learn about other benefits and more. Ready?

Let's get started

1. Review plan features and benefits.
2. Search the network to find a dentist.
3. Enroll.

Prefer to talk to a person? We're here to help. 1-877-816-3596

1 Review plan features and benefits.

Check out features included in the dental plan options, each designed to help you take care of your oral health and save money.

DENTAL PLAN FEATURES	High Plan	Low Plan	DHMO Plan
Preventive care is covered at 100% in the network.	✓	✓	✓
Access a national network of dental providers.	✓	✓	✓
You can see any dentist, but staying in network can help lower your costs.	✓	✓	✓
Waiting periods do not apply with this plan.	✓	✓	✓
Extra dental visits for expectant mothers.[1]	✓	✓	✓
Access a dental cost calculator for out-of-pocket costs.	✓	✓	✓
Access to SmileDirectClub.	✓	✓	✓

Preventive care may help improve oral health. Your network preventive care benefits include:

- Cleanings covered each year.
- Annual oral cancer screenings for covered adults (ages 18 and older).
- Extra cleanings and treatments for expectant mothers.[1]

Good dental hygiene may help prevent gum disease, which can be painless, but serious, and connected to:

- Diabetes
- Heart disease
- Pregnancy complications
- Respiratory conditions
- Rheumatoid arthritis

Get started on a straighter, brighter smile with SmileDirectClub:

- Aligner treatment (your dental plan may pay half).
- 3D digital image at a SmileShop or an at-home kit ($0 cost with rebate).
- Retainer following completion ($0 cost with subscription).
- **bright on™** premium teeth whitening ($0 cost).
- Find out more at **smiledirectclub.com/uhc.**

We're here to help. **1-877-816-3596**

Review dental plan benefits.

Here are more details to help you understand your plan.

	High Plan		Low Plan	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible*	$50/$50	$200/$200	$50/$50	$200/$200
Annual Maximum*	$4,000	$4,000	$3,000	$3,000
Dental Services	**Two cleanings covered each year**		**Two cleanings covered each year**	
Preventive Services	100%	60%	100%	60%
Basic Services	100%	60%	100%	60%
Major Services	80%	50%	80%	50%
Orthodontic Services	**No waiting period**		**No waiting period**	
Eligiblity	Adult & Child		Adult & Child	
Lifetime Maximum	$3,000	$3,000	$2,500	$2,500
Benefit Pays	60%	50%	60%	50%

*per person and does not apply to orthodontics

2 Search the network to find a dentist.

Using a network provider can help lower your costs. To get started:

- Go to **myuhc.com.**
- Scroll down to Find a Dentist and start your search.
- Follow the directions to make your choice.

3 Enroll.

Now that you've had a chance to review your dental plan options, you're ready to get started. Talk to your employer or benefits administrator about next steps.

After you enroll, tap into your benefits.

Go to **myuhc.com**® to find a nearby dentist, manage claims and more.

Prefer to talk to a person? We're here to help. **1-877-816-3596**

	High Plan			
	Non-Orthodontics		Orthodontics	
	Network	Non-Network	Network	Non-Network
Individual Annual Deductible	$50	$200	$0	$0
Family Annual Deductible	$50	$200	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	$4,000 per person per calendar year	$4,000 per person per calendar year	$3,000 per person per lifetime	$3,000 per person per lifetime
New Enrollee's Waiting Period	None			
Annual Deductible Applies to Preventive and Diagnostic Services	No	No		
Preventive Annual Deductible Applies to Orthodontic Services			No	
Orthodontic Eligibility Requirement			Adult & Child	

Covered Services*	Network Plan Pays**	Non-Network Plan Pays**	Benefit Guidelines
Diagnostic Services			
Periodic Oral Evaluation	100%	60%	See Exclusions and Limitations section for benefit guidelines.
Radiographs	100%	60%	
Lab and Other Diagnostic Tests	100%	60%	
Preventive Services			
Prophylaxis (cleaning)	100%	60%	See Exclusions and Limitations section for benefit guidelines.
Fluoride Treatment (preventive)	100%	60%	
Sealants	100%	60%	
Space Maintainers	100%	60%	
Basic Services			
Restorations, Amalgams or Composite (anterior & posterior)	100%	60%	See Exclusions and Limitations section for benefit guidelines.
Emergency Treatment/General Services	Split Class	Split Class	
Simple Extractions	100%	60%	
Oral Surgery (includes surgical extractions)	100%	60%	
Periodontics	100%	60%	
Endodontics	100%	60%	
Major Services			
Inlays/Onlays/Crowns	80%	50%	See Exclusions and Limitations section for benefit guidelines.
Dentures and Removable Prosthetics	60%	50%	
Fixed Partial Dentures (bridges)	80%	50%	
Implants	80%	50%	
Orthodontic Services			
Diagnose or correct misalignment of the teeth or bite	60%	50%	

Covered dental services.

	Low Plan			
	Non-Orthodontics		Orthodontics	
	Network	Non-Network	Network	Non-Network
Individual Annual Deductible	$50	$200	$0	$0
Family Annual Deductible	$50	$200	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	$3,000 per person per calendar year	$3,000 per person per calendar year	$2,500 per person per lifetime	$2,500 per person per lifetime
New Enrollee's Waiting Period	None			
Annual Deductible Applies to Preventive and Diagnostic Services	No	No		
Preventive Annual Deductible Applies to Orthodontic Services			No	
Orthodontic Eligibility Requirement			Adult & Child	

Covered Services*	Network Plan Pays**	Non-Network Plan Pays**	Benefit Guidelines
Diagnostic Services			
Periodic Oral Evaluation	100%	60%	See Exclusions and Limitations section for benefit guidelines.
Radiographs	100%	60%	
Lab and Other Diagnostic Tests	100%	60%	
Preventive Services			
Prophylaxis (cleaning)	100%	60%	See Exclusions and Limitations section for benefit guidelines.
Fluoride Treatment (preventive)	100%	60%	
Sealants	100%	60%	
Space Maintainers	100%	60%	
Basic Services			
Restorations, Amalgams or Composite (anterior & posterior)	100%	60%	See Exclusions and Limitations section for benefit guidelines.
Emergency Treatment/General Services	Split Class	Split Class	
Simple Extractions	1000%	60%	
Oral Surgery (includes surgical extractions)	100%	60%	
Periodontics	100%	60%	
Endodontics	100%	60%	
Major Services			
Inlays/Onlays/Crowns	80%	50%	See Exclusions and Limitations section for benefit guidelines.
Dentures and Removable Prosthetics	60%	50%	
Fixed Partial Dentures (bridges)	80%	50%	
Implants	80%	50%	
Orthodontic Services			
Diagnose or correct misalignment of the teeth or bite	60%	50%	

	DMO			
	Non-Orthodontics		Orthodontics	
	Network	Non-Network	Network	Non-Network
Individual Annual Deductible	See Copay Schedule			
Family Annual Deductible	See Copay Schedule			
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	See Copay Schedule			
New Enrollee's Waiting Period	See Copay Schedule			
Annual Deductible Applies to Preventive and Diagnostic Services	See Copay Schedule			
Preventive Annual Deductible Applies to Orthodontic Services	See Copay Schedule			
Orthodontic Eligibility Requirement	See Copay Schedule			

Covered Services*	Network Plan Pays**	Non-Network Plan Pays**	Benefit Guidelines
Diagnostic Services			
Periodic Oral Evaluation	See Copay Schedule		See Exclusions and Limitations section for benefit guidelines.
Radiographs			
Lab and Other Diagnostic Tests			
Preventive Services			
Prophylaxis (cleaning)	See Copay Schedule		See Exclusions and Limitations section for benefit guidelines.
Fluoride Treatment (preventive)			
Sealants			
Space Maintainers			
Basic Services			
Restorations, Amalgams or Composite (anterior & posterior)	See Copay Schedule		See Exclusions and Limitations section for benefit guidelines.
Emergency Treatment/General Services			
Simple Extractions			
Oral Surgery (includes surgical extractions)			
Periodontics			
Endodontics			
Major Services			
Inlays/Onlays/Crowns	See Copay Schedule		See Exclusions and Limitations section for benefit guidelines.
Dentures and Removable Prosthetics			
Fixed Partial Dentures (bridges)			
Implants			
Orthodontic Services			
Diagnose or correct misalignment of the teeth or bite	See Copay Schedule		

Discover the connection between good oral health and better overall health.

Dental wellness.

Taking care of your oral health with regular dental visits plays a key role in your overall well-being. When you see a network dentist, your plan covers preventive dental care.

Wellness benefits are covered at 100 percent when you see a network dentist. Benefits include:

Two routine checkups in a 12-month period — one every 6 months.

- Includes cleanings.
- Some plans cover more cleanings for an additional copay.

Annual oral cancer screenings for covered adults (ages 18 and older).

Screenings may include:

- Light contrast screening: A test that uses light to help your dentist find healthy and unhealthy tissue.
- Brush biopsy: A tissue sample taken from a suspicious area.

Extra cleanings and gum treatments for expectant mothers — as recommended by your dentist.*

The coverage includes:

- Dental cleanings while you're pregnant and 3 months following delivery.
- Deep scaling (non-surgical gum treatment).
- Gum maintenance.

Ask your dentist to include the name of your obstetrician and your due date on your dental claim. Share this letter with your dental office to inform them of this benefit. We'll handle the rest.

50%

of U.S. adults older than 30 have gum disease.[2]

Take advantage of your dental plan to help keep your gums in check.

How oral health can affect pregnancy.

Gum disease in pregnant women may be linked to complications like pre-term births and low birth weights.[3]

Adopting good oral health habits when young helps prevent issues when older.

Help your kids start good habits early.

- When your child's teeth first appear, brush them twice daily with a soft toothbrush or wipe with soft gauze or a washcloth.
- Make first dental appointment at age 1.
- At age 3, add a pea-sized dab of fluoride toothpaste and continue to brush their teeth twice a day.
- Floss when teeth start touching.
- Limit sugary snacks and drinks.
- Provide meals from the 5 basic food groups.
- Take your child to the dentist regularly and ask about sealants and fluoride supplements.

Regular screenings can help reduce risk of:

Diabetes
Diabetics have a weakened immune system, which may make it harder to keep bacteria from causing gum disease and raising blood glucose levels.

Heart disease
Gum disease allows bacteria to get into your bloodstream and puts you at risk for heart attack and stroke.

Respiratory conditions
Gum disease bacteria can be inhaled into your lungs, and increase your risk of pneumonia and infections.

Rheumatoid arthritis
Gum disease can increase the severity of arthritis.

Discover the mouth-body connection.

Your mouth reflects your overall health.

Your dentist can detect signs of disease.

Infections in your mouth can affect your entire body.

Know the warning signs.

Gum disease is a painless condition many people don't realize they have until it's already done significant damage. When your gums become infected, bacteria and toxins enter your bloodstream, which may worsen other health conditions. If you experience any of the following, see your dentist immediately.

- Red, swollen or tender gums.
- Gums that bleed when you brush.
- Bad breath.
- Loose teeth.
- Changes in how teeth fit together.

#1

chronic infectious disease to affect children is tooth decay.[4]

1 in 5

cases of total tooth loss are linked to diabetes.[5]

4x

higher risk of stroke for people with severe gum disease.[6]

Learn more about our dental plan and benefits.

View your dental plan benefits and cost tools at **myuhc.com®.**

Get more wellness tips.
Find out more about dental wellness at **uhc.com/dental-health.**

Get a smile you'll love — for a lifetime of confidence.

Now available as part of your UnitedHealthcare orthodontic benefit, SmileDirectClub straightens teeth with clear aligners sent directly to you.

With SmileDirectClub, most new smiles only take about 6 months on average[8] — plus, you can look forward to:

- Not having braces.
- Not scheduling monthly office visits.

SmileDirectClub + UnitedHealthcare =

A smile you may love for less than $1,000 out-of-pocket.[7]

Get started on a straighter, brighter smile with this new benefit.

If you're a candidate, your dental plan may pay half the cost of your aligner treatment. Your benefit also includes these services at no extra cost:

- A free 3D digital image at one of 235 SmileShops ($0 cost) or an at-home impression kit ($0 cost with rebate).
- A free retainer following completion of your smile journey ($0 cost with subscription).
- **bright on**™ premium teeth whitening ($0 cost).
- You'll be assigned a duly licensed dentist or orthodontist to develop your treatment plan and monitor your progress.

Don't wait — find out if you're a candidate today at **smiledirectclub.com/uhc.**

Smiling is contagious. Join the club.

If you or your covered dependents are candidates, you can transform your smile in **3 easy steps** with SmileDirectClub's innovative at-home program.

Here's how it works.

1 Make an impression.

Visit one of SmileDirectClub's more than 235 SmileShops for a free 3D digital image of your smile ($0 cost). Or, you can order an at-home impression kit online ($0 cost with rebate).

2 Get aligned.

A duly licensed dentist or orthodontist will create your smile plan, and your clear aligners will be sent to your door. Your new smile kit will also include **bright on™** premium teeth whitening, so you can show off those pearly whites.

3 Keep smiling.

Your dentist will check in with you online every 90 days to monitor your progress. After your new smile is complete, you'll get your first retainer ($0 cost with subscription). Wear it at night to keep your new smile in place, and feel free to order touch-up whitening treatments anytime.

Your new smile is waiting.

Visit **smiledirectclub.com/uhc.**

Frequently asked questions.

1. **Q: Will I get a UnitedHealthcare dental ID card?**
   A: All new members get an ID card. If you already have a UnitedHealthcare dental plan, you may not get a new card. Keep using the one you have. Your card only lists the name of the person who signed up for the plan, but everyone your plan covers should use the card. Be sure to bring it with you each time you see the dentist.

   Print your ID card anytime at **myuhc.com.**

2. **Q: How do I make an appointment?**
   A: Call your dentist to make an appointment. Let the dental office know you have a UnitedHealthcare dental plan, and show your dental ID card at your appointment.

3. **Q. How do I check on a claim?**
   A: To check on a claim, log in to your member website at **myuhc.com.** Or call the toll-free customer care number on your ID card. The automated system is available 24 hours a day, 7 days a week.

4. **Q. Do I need to see a dentist in the network?**
   A: You'll get discounts and save money when you see a dentist in the network. Your out-of-pockets costs will almost always be higher if you see a dentist outside the network.

5. **Q. Does UnitedHealthcare pay out-of-network dentists directly?**
   A: UnitedHealthcare pays all dentists directly. We can't require out-of-network dentists to accept payments from us, but most do.

6. **Q. How do I find a network dentist?**
   A: Finding a network dentist is easy. You have two options:

   1. Log in to **myuhc.com** and use the Find a Dentist tool. You'll see a list of dentists who are part of your network. (If you don't log in to the member website, you can still use the search tool, but you have to choose your network from the list. The name of your network is printed on your ID card.)
   2. Call the customer care number on your ID card. If a network dental provider is not available within a reasonable distance of where you live or work, you may be referred or directed to an out-of-network dental provider. Please see your official dental plan documents for all of the details about your plan coverage.

7. **Q. Can I ask UnitedHealthcare to add my dentist to the network?**
   A: If you want your dentist to be part of the network, visit **myuhc.com** and fill out the provider nomination form. Or, call customer care at the number on your ID card.

8. **Q. I started dental work when I had a different insurance plan. What happens now?**
   A: Your old plan should pay for any dental work that was started until it's finished. For example, if your dentist did prep work for a crown on Dec. 29, but didn't place the crown until after you switched to UnitedHealthcare on Jan. 1, your old dental plan will cover the charges for the whole procedure.

   On your dental bill, if the date you received care is before you switched to UnitedHealthcare, submit a claim to your old plan. (In some cases, depending on what your old plan covered, you may need to pay the bill.) UnitedHealthcare will handle any dental care you receive after Jan. 1.

9. **Q. What happens if I switch to UnitedHealthcare when I have braces?**
   A: If you switch dental plans, when your new plan is active, UnitedHealthcare plan will pay for your care on a prorated basis. Your coverage will depend on the time left in your treatment plan and your benefit level.

10. **Q. How do I submit a claim?**
    A: In most cases, your dentist will submit your claim for you. If you need to submit a claim, send it to the address listed on your ID card:

    UnitedHealthcare
    Attn: Claims Unit
    P.O. Box 30567
    Salt Lake City, UT 84130-0567

Need help?

Visit myuhc.com. Log in to your member website for 24/7 access to personal details about your dental plan:

- Estimate treatment costs
- Search for dentists
- Print an ID card
- View your claims history

Call toll-free.
Call customer care at the number on your ID card anytime you have a question. The automated system is available 24 hours a day, 7 days a week.

The company does not treat members differently because of sex, age, race, color, disability or national origin. If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator, UnitedHealthcare Civil Rights Grievance, P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call 1-800-445-9090, TTY 711. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf **Complaint forms are available at** hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711

您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員, 請撥打您健保計劃會員卡上的免付費會員電話號碼, 再按 0。聽力語言殘障服務專線 711

Quý v□ có quy□n đ□□c giúp đ□ và c□p thông tin b□ng ngôn ng□ c□a quý v□ mi□n phí. Đ□ yêu c□u đ□□c thông d□ch viên giúp đ□, vui lòng g□i s□ đi□n tho□i mi□n phí dành cho h□i viên đ□□c nêu trên th□ ID ch□□ng trình b□o hi□m y t□ c□a quý v□, b□m s□ 0. TTY 711

귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711

May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711

Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711

لك الحق في تلقّي مساعدة ومعلومات باللغة التي تختارها دون تحمّل أي تكلفة. اتصل على الرقم المجاني المدوّن على بطاقة هويتك الصحية واضغط 0 للتحدث إلى مترجم فوري. (TTY) 711

Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711

Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.

Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711

Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711

Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711

ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。

شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن ۷۱۱ TTY حاصل و درخواست دهید.

Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

A. Necessary;
B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
C. The least costly, clinically accepted treatment, and
D. Not excluded as described in the Section entitled. General Exclusions.

GENERAL LIMITATIONS

1. PERIODIC ORAL EVALUATION Limited to 2 times per calendar year.
2. COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 60 months.
3. BITEWING RADIOGRAPHS Limited to 2 series of films per calendar year.
4. EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.
5. DENTAL PROPHYLAXIS Limited to 2 times per calendar year
6. FLUORIDE TREATMENTS Limited to covered persons under the age of 14 years, and limited to 2 times per calendar year.
7. SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. SEALANTS Limited to covered persons under the age of 18 years, and once per first or second permanent molar every consecutive 36 months
9. RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling. Composite restorations allowed on all teeth.
10. PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.
11. INLAYS, ONLAYS, AND VENEERS Limited to 1 time per tooth per 10 years. Covered only when a filling cannot restore the tooth.
12. CROWNS Limited to 1 time per tooth per 10 years. Covered only when a filling cannot restore the tooth.
13. POST AND CORES Covered only for teeth that have had root canal therapy.
14. SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
15. SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.
16. ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.
17. PERIODONTAL MAINTENANCE Limited to 2 times per calendar year following active or adjunctive periodontal therapy, exclusive of gross debridement.
18. FULL DENTURES Limited to 1 time every every 10 years. No additional allowances for precision or semi-precision attachments.
19. PARTIAL DENTURES Limited to 1 time every 10 years. No additional allowances for precision or semi-precision attachments.
20. RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
21. REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 6 months after the initial insertion.
22. PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
23. OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
24. FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.
25. GENERAL ANESTHESIA Covered only when clinically necessary.
26. OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
27. PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
28. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 10 years from initial or supplemental placement. This includes retainers, habit appliances and any fixed or removable interceptive orthodontic appliances.
29. CONE BEAM Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

The following are not covered:

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
9. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
10. 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.

11. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
12. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
13. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.
14. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
15. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
16. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
17. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
18. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
19. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
20. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups sitused in the state of Arizona, in order to comply with state regulations.
21. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
22. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
24. Foreign Services are not Covered unless required as an Emergency.
25. 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.
26. 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.

United Healthcare®

[1] Not available in the state of Washington.

[2] Eke P, Dye BA, Wei L, Thornton-Evans GO, Genco RJ. Prevalence of periodontitis in adults in the United States: 2009 and 2010. J Dent Res 2012; 91(10):914-920. Published online Aug. 30, 2012.

[3] https://www.perio.org/consumer/AAP_EFP_Pregnancy.

[4] Children's Oral Health," U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, http://www.cdc.gov/OralHealth/topics/child.htm, page last modified: Jan. 7, 2011.

[5] The American Dental Association. "Diabetes."

[6] Grau, Armin J. et al. "Periodontal Disease as a Risk Factor for Ischemic Stroke." Stroke. 2004. http://stroke.ahajournals.org/content/35/2/496.full.

[7] SmileDirectClub is available to members enrolled in a UnitedHealthcare Dental Preferred Provider Organization (PPO) or In-Network Only (INO) plan that includes orthodontic coverage. Cost of less than $1,000 is based on a UnitedHealthcare national dental plan design for employee-only coverage with a 50 percent orthodontic benefit. Not all individuals are suitable candidates for clear aligners. These services are intended for certain individuals who have mild or moderate orthodontic needs.

[8] SmileDirectClub treatment plan average results, 2018.

This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or the company. UnitedHealthcare dental coverage underwritten by UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), DBP Services (NY only), United HealthCare Services, Inc. or their affiliates.] [Plans sold in Texas use policy form number DPOL06.TX, DPOL 12.TX and DPOL 12.TX (Rev. 9/16) and associated COC form numbers DCOC.CER.06, DCOC.CER.IND.12.TX and DCERT.IND.12.TX.] (Plans sold in Virginia use policy form number DPOL06.VA with associated COC form number.

DCOC.CER.06.VA and policy form number DPOL 12.VA with associated COC form number DCOC.CER.12.VA.

This policy DOES NOT include coverage of pediatric dental services as required under federal law. Coverage of pediatric dental services is available for purchase in the State of Colorado, and can be purchased as a stand-alone plan, or as a covered benefit in another health plan. Please contact your insurance carrier, agent or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-qualified stand-alone dental plan that includes pediatric dental coverage.

*Not available in the state of Washington.

The information provided is for educational purposes only. If you have a UnitedHealthcare Dental plan, please refer to your certificate of coverage for a full description of benefits.

Policies have exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, please see your official dental plan documents.

Benefits for the UnitedHealthcare dental DHMO plans are provided by or through the following UnitedHealth Group companies: Nevada Pacific Dental, National Pacific Dental, Inc. and Dental Benefit Providers of Illinois, Inc. Plans sold in Texas use contract form number DHMO.CNT.11.TX and associated EOC form number DHMO.EOC.11.TX.

The New York Select Managed Care Plan is underwritten by UnitedHealthcare Insurance Company of New York located in Islandia, New York. Administrative services provided by DBP Services. The Select DHMO plan is underwritten by Dominion Dental Services, Inc. Dominion is licensed as a Limited Health Care Services HMO in Virginia, Pennsylvania and a Dental Plan Organization in Maryland and Delaware.

Benefits for the UnitedHealthcare Dental DHMO/Direct Compensation plans are offered by Dental Benefit Providers of California, Inc. UnitedHealthcare Dental is affiliated with UnitedHealthcare.

Benefits and programs may not be available in all states or for all group sizes. Components subject to change. These policies have exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, see your official dental plan documents.

UnitedHealthcare dental coverage underwritten by UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), DBP Services (NY only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX and associated COC form number DCOC.CER.06. Plans sold in Virginia use policy form number DPOL.06.VA and associated COC form number DCOC.CER.06.VA. This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or UnitedHealthcare Insurance Company.

Solstice S700B-SHP/D1058

Members of the Solstice S700B-SHP Dental Plan are eligible to receive benefits immediately upon the effective date of coverage with:

- No Waiting Periods
- No Deductibles or Maximums
- No Claim Forms to Submit

The member co-payments listed are offered by a participating in-network general dentists. The member receives:

- Most diagnostic & preventive care at No Charge
- Cosmetic & orthodontia treatment covered

Members can locate a participating provider at
www.myuhc.com
Member Services Department: 800-955-4137

The member is ultimately responsible for verifications of the accuracy and appropriateness of all fees applicable to any dental benefit provided by a network provider. We urge all of our members to verify all fees for proposed treatment via the "Schedule of Benefits" and/or with our Member Services Department prior to treatment.

The following Member co-payments apply when a participating General Dentist performs services. An "*" denotes limitations on certain benefits (see "Exclusions/Limitations").

ADA	DESCRIPTION	MEMBER PAYS
DIAGNOSTIC SERVICES		
D0120	PERIODIC ORAL EVALUATION EST PT	$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$0
D0145	ORAL EVAL PT<3 AND COUNSEL	$0
D0150	COMP ORAL EVALUATION - NEW/EST PT	$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS REPORT	$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	$0
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE VISIT	$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC IMAGES	$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$4
D0230	INTRAORL PERIAPICAL EACH ADD RADIOGRAPHIC IMAGE	$2
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$0
D0251	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$29
D0310	RADIOGRAPHS -SIALOGRAPHY	$150
D0320	TMJ - INCLUDING INJECTION	$250
D0321	OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES	$150
D0322	TOMOGRAPHIC SURVEY	$150
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$50
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$125
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY	$20
D0364	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$169
D0365	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$149
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$139
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$139
D0368	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$184
D0369	MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION	$139
D0370	MAXILLOFACIAL ULTRASOUND CAPTURE AND INTERPRETATION	$189
D0371	SIALOENDOSCOPY AND CAPTURE AND INTERPRETATION	$169
D0380	CONE BEAM CT IMAGE CAPTURE WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$169
D0381	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$149
D0382	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$139
D0383	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF BOTH JAWS	$139
D0384	CONE BEAM CT IMAGE CAPTURE FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$184
D0385	MAXILLOFACIAL MRI IMAGE CAPTURE	$139
D0386	MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	$169
D0393	SIMULATION USING 3D IMAGES	$9
D0394	DIGITAL SUBTRACTION OF IMAGES	$9
D0395	FUSION OF TWO OR MORE 3D IMAGES	$9
D0414	LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0
D0415	COLLECT MICROORGANISMS CULT & SENS	$0

This plan is underwritten by Solstice, Inc. Administered by Dental Benefit Providers, Inc.

ADA	DESCRIPTION	MEMBER PAYS
DIAGNOSTIC SERVICES		
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$65
D0460	PULP VITALITY TESTS	$0
D0470	DIAGNOSTIC CASTS	$0
D0472	ACCESS TISSUE, GROSS EXAM - PREP & REPORT	$0
D0473	ACCESS TISSUE, GROSS & MICROSCOPIC - PREP/REPORT	$0
D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	$0
D0480	PROCESSING AND INTERP OF EXFOLIATIVE CYTOLOGICAL SMEARS, INCL PREP AND TRANS OF WRITTEN REPORT	$0
D0486	ACCESSION OF TRANSEPITHELIAL CYTOLOGIC SAMPLE, MICCROSCOPIS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0
D0502	OTHER ORAL PATHOLOGY PROCEDURES	$0
D0600	NON-IONIZING DIAGNOSTIC PROCEDURE CAPABLE OF QUANTIFYING, MONITORING, AND RECORDING CHANGES IN STRUCTURE OF ENAMEL, DENTIN AND CEMENTUM	$0
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$0
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$0
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$0
PREVENTIVE SERVICES		
D1110	PROPHYLAXIS - ADULT	$0
D1110_In 6Mo	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	$20
D1120	PROPHYLAXIS - CHILD	$0
D1120_In 6Mo	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6 MONTHS	$20
D1206	TOPICALFLUORIDE VARNISH	$15
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$0
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	$0
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	$0
D1330	ORAL HYGIENE INSTRUCTIONS	$0
D1351	SEALANT - PER TOOTH	$0
D1352	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$0
D1353	SEALANT REPAIR – PER TOOTH	$0
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION	$20
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	$0
D1551	RECEM/REBOND BILATERAL SPACE MAINTAINER – MAXIL	$15
D1552	RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB	$15
D1553	RECEM/REBOND UNILATERAL SPACE MAINTAINER/QUAD	$15
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER/QUAD	$15
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	$15
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	$15
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED, UNILATERAL/QUAD	$0
RESTORATIVE SERVICES		
D2140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	$0
D2150	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	$0
D2160	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	$0
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	$30
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	$37
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	$50
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	$80
D2390	RESIN COMPOSITE CROWN ANTERIOR	$115
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	$65
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	$75
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	$90
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	$115
D2410	GOLD FOIL - ONE SURFACE	$75
D2420	GOLD FOIL - TWO SURFACES	$95
D2430	GOLD FOIL - THREE SURFACES	$125
D2510	INLAY - METALLIC - ONE SURFACE	$225
D2520	INLAY - METALLIC - TWO SURFACES	$235
D2530	INLAY - METALLIC - 3/MORE SURFACES	$245
D2542	ONLAY - METALLIC - TWO SURFACES	$325
D2543	ONLAY - METALLIC THREE SURFACES	$340
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	$350
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	$275
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$300
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	$325
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$360
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	$390
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	$400
D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	$200
D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	$220
D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	$260
D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	$240
D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	$260
D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	$283
D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	$195
D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	$195
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	$245
D2721	CROWN - RESIN W/PREDOM BASE METAL	$245
D2722	CROWN - RESIN WITH NOBLE METAL	$245
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$245
D2750	CROWN - PORCELAIN FUSED HI NOBLE METAL	$245
D2751	CROWN - PORCELAIN FUSED PREDOM BASE METAL	$245
D2752	CROWN - PORCELAIN FUSED NOBLE METAL	$245
D2753	CROWN PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$245
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	$245
D2781	CROWN - 3/4 CAST PREDOM BASE METAL	$245
D2782	CROWN - 3/4 CAST NOBLE METAL	$245
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$245
D2790	CROWN - FULL CAST HIGH NOBLE METAL	$245
D2791	CROWN - FULL CAST PREDOM BASE METAL	$245
D2792	CROWN - FULL CAST NOBLE METAL	$245
D2794	CROWN - TITANIUM AND TITANIUM ALLOYS	$245
D2799	PROVISIONAL CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$125
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$15

ADA	DESCRIPTION	MEMBER PAYS
RESTORATIVE SERVICES		
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFABRICATED POST & CORE	$20
D2920	RECEMENT OR RE-BOND CROWN	$15
D2921	REATTACHMENT OF TOOTH FRAGMENT	$15
D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	$49
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	$45
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	$55
D2932	PREFABRICATED RESIN CROWN	$95
D2933	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	$145
D2940	SEDATIVE FILLING	$15
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$15
D2949	RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION	$20
D2950	CORE BUILDUP INCLUDING ANY PINS	$70
D2951	PIN RETENTION - PER TOOTH ADDITION REST	$15
D2952	POST & CORE ADD CROWN INDIRECT FAB	$88
D2953	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	$95
D2954	PREFABRICATED POST & CORE ADDITION CROWN	$75
D2955	POST REMOVAL	$30
D2957	EACH ADD PREFABR POST - SAME TOOTH	$30
D2960	LABIAL VENEER (LAMINATE) - CHAIRSIDE	$200
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$255
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$390
D2971	ADD PROCEDURE NEW CROWN XST PART DENTURE	$45
D2975	COPING	$95
D2980	CROWN REPAIR	$95
D2981	INLAY REPAIR	$95
D2982	ONLAY REPAIR	$95
D2983	VENEER REPAIR	$95
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$29
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$25
D3120	PULP CAP - INDIRECT	$25
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL JUNC	$30
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT TEETH	$95
D3222	PARTIAL PULPOTOMY	$75
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$50
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$50
D3310	ANTERIOR	$110
D3320	BICUSPID	$195
D3330	MOLAR	$245
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$85
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$75
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$125
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$300
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$350
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$440
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	$90
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	$90
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$90
D3410	APICOECTOMY SURG - ANT	$100
D3421	APICOECTOMY SURG-BICUSPID	$315
D3425	APICOECTOMY SURG - MOLAR	$340
D3426	APICOECTOMY SURGERY	$95
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$100
D3428	BONE GRAFT WITH PERIRADICULAR SURGERY PER TOOTH	$47
D3429	BONE GRAFT WITH PERIRADICULAR SURGERY EACH ADDITIONAL TOOTH	$42
D3430	RETROGRADE FILLING - PER ROOT	$75
D3431	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	$150
D3432	GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE	$150
D3450	ROOT AMPUTATION - PER ROOT	$110
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$545
D3470	INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING)	$175
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$95
D3920	HEMISECTION NOT INCL RC THERAPY	$90
D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	$75
PERIODONTIC SERVICES		
D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	$175
D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	$81
D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST PROC/TOOTH	$49
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$195
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$185
D4245	APICALLY POSITIONED FLAP	$150
D4249	CLIN CROWN LEN - HARD TISSUE	$230
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$375
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$325
D4263	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	$450
D4264	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – EACH ADDITIONAL SITE IN QUADRANT	$325
D4265	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	$325
D4266	GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER SITE	$325
D4267	GUIDED TISSUE REGENERATION - NONRESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL)	$325
D4268	SURGICAL REVISION PROCEDURE, PER TOOTH	$0
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$250
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$335
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$125
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$502
D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH	$65
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$215
D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH	$75

ADA	DESCRIPTION	MEMBER PAYS
PERIODONTIC SERVICES		
D4283	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	$299
D4285	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	$392
D4320	PROVISIONAL SPLINTING - INTRACORONAL	$115
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$105
D4341	PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD	$50
D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	$43
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$50
D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX ON A SUBSEQUENT VISIT	$50
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$60
D4910	PERIODONTAL MAINTENANCE	$50
D4920	UNSCHEDULED DRESSING CHANGE	$25
D4921	GINGIVAL IRRIGATION PER QUADRANT	$15
D4999	UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT	$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110	COMPLETE DENTURE - MAXILLARY	$325
D5120	COMPLETE DENTURE - MANDIBULAR	$325
D5130	IMMEDIATE DENTURE - MAXILLARY	$350
D5140	IMMEDIATE DENTURE - MANDIBULAR	$350
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	$400
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$400
D5213	MAX PART DENTUR-CAST METL W/RSN	$425
D5214	MAND PART DENTUR- CAST METL W/RSN	$425
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$420
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$420
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$445
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$445
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$425
D5226	MANDIBULAR PART DENTURE FLEX BASE	$425
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE – FLEX BASE/QUAD	$425
D5286	REMOVABLE UNILATERAL PARTIAL DENTURE-RESIN/QUAD	$425
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$15
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$15
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$15
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$15
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	$35
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$35
D5520	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$35
D5621	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$35
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$35
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$35
D5640	REPLACE BROKEN TEETH - PER TOOTH	$35
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$35
D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$35
D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK MAXILLARY	$155
D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK MANDIBULAR	$155
D5710	REBASE COMPLETE MAXILLARY DENTURE	$135
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$135
D5720	REBASE MAXILLARY PARTIAL DENTURE	$155
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$155
D5730	RELINE COMPLETE MAXILLARY DENTURE CHAIRSIDE	$65
D5731	RELINE COMPLETE MANDIBULAR DENTURE CHAIRSIDE	$65
D5740	RELINE MAXILLARY PARTIAL DENTURE CHAIRSIDE	$65
D5741	RELINE MANDIBULAR PARTIAL DENTURE CHAIRSIDE	$65
D5750	RELINE COMPLETE MAXILLARY DENTURE LAB	$85
D5751	RELINE COMPLETE MANDIBULAR DENTURE LABORATORY	$85
D5760	RELINE MAXILLARY PARTIAL DENTURE LAB	$85
D5761	RELINE MANDIBULAR PARTIAL DENTURE LABORATORY	$85
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$250
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$250
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$175
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$175
D5850	TISSUE CONDITIONING MAXILLARY	$20
D5851	TISSUE CONDITIONING MANDIBULAR	$20
D5862	PRECISION ATTACHMENT, BY REPORT	$150
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT	$0
IMPLANT SERVICES		
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,010
D6012	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT	$1,010
D6056	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$440
D6057	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$550
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$750
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$750
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$750
D6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$750
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$750
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$750
D6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$750
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$750

ADA	DESCRIPTION	MEMBER PAYS
IMPLANT SERVICES		
D6066	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$750
D6067	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	$750
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$750
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$750
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$750
D6071	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$750
D6072	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$750
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$750
D6074	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$750
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$750
D6076	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$750
D6077	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	$750
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$180
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	$50
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$750
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS	$750
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$750
D6085	PROVISIONAL IMPLANT CROWN	$125
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE ALLOYS	$750
D6087	IMPLANT SUPPT CROWN-NOBLE ALLOYS	$750
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM ALLOYS	$750
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$400
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	$45
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$65
D6094	ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	$750
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$220
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$500
D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$750
D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$750
D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	$750
D6100	IMPLANT REMOVAL, BY REPORT	$700
D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$1,255
D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$1,255
D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$995
D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$995
D6114	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$3,855
D6115	IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$3,855
D6115	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$3,855
D6116	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$2,255
D6117	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$2,255
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$1,804
D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$1,804
D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$750
D6121	IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS	$750
D6122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	$750
D6123	IMPLANT SUPPT RETAINER FOR METAL FPD-TITANIUM/TITANIUM ALLOYS	$750
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$235
D6195	ABUTMENT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$750
FIXED PROSTHODONTIC SERVICES		
D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	$750
D6210	PONTIC - CAST HIGH NOBLE METAL	$245
D6211	PONTIC - CAST PREDOM BASE METAL	$245
D6212	PONTIC - CAST NOBLE METAL	$245
D6214	PONTIC - TITANIUM AND TITANIUM ALLOYS	$245
D6240	PONTIC - PORCELAIN FUSED HI NOBLE METAL	$245
D6241	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	$245
D6242	PONTIC - PORCELAIN FUSED NOBLE METAL	$245
D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$245
D6245	PONTIC - PORCELAIN/CERAMIC	$245
D6250	PONTIC - RESIN W/HIGH NOBLE METAL	$245
D6251	PONTIC RESIN W/PREDOM BASE METAL	$245
D6252	PONTIC RESIN W/NOBLE METAL	$245
D6253	PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$0
D6545	RETAINER - CASE METAL FOR RESIN FIXED PROSTHESIS	$390
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	$225
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2 SURFACES	$245
D6601	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$245
D6602	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	$245
D6603	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	$245
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	$245
D6605	RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES	$245

ADA	DESCRIPTION	MEMBER PAYS
FIXED PROSTHODONTIC SERVICES		
D6606	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$245
D6607	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	$245
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	$245
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$245
D6610	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	$245
D6611	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	$245
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	$245
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	$245
D6614	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$245
D6615	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	$245
D6624	RETAINER INLAY - TITANIUM	$245
D6634	RETAINER ONLAY - TITANIUM	$245
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$245
D6720	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$245
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$245
D6722	RETAINER CROWN - RESIN WITH NOBLE METAL	$245
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$245
D6750	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$245
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$245
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$245
D6753	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$245
D6780	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$245
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$245
D6782	RETAINER CROWN - 3/4 CAST NOBLE METAL	$245
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$245
D6784	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	$245
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$245
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$245
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	$245
D6793	PROVISIONAL RETAINER CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$125
D6794	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	$245
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$15
D6940	STRESS BREAKER	$125
D6950	PRECISION ATTACHMENT	$195
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$80
ORAL SURGERY SERVICES		
D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	$50
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$20
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$30
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$50
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$65
D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	$80
D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	$135
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$40
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	$270
D7260	OROANTRAL FISTULA CLOSURE	$160
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$275
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	$50
D7272	TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)	$100
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$125
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	$125
D7283	PLACEMENT DEVICE FACILITATE ERUPT IMPACTED TOOTH	$80
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$125
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$85
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$75
D7288	BRUSH BIOPSY	$25
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	$40
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$40
D7311	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	$40
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$60
D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	$60
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$370
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$990
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	$25
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	$50
D7412	EXCISION OF BENIGN LESION, COMPLICATED	$55
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$65
D7471	REMOVAL OF LATERAL EXOSTOSIS	$95
D7472	REMOVAL OF TORUS PALATINUS	$95
D7473	REMOVAL OF TORUS MANDIBULARIS	$95
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$95
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	$20
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$20
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$20
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$35
D7921	COLLECTION AND APPLICATION OF AUTOLOGOUS BLOOD CONCENTRATE PRODUCT	$125
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES - AUTOGENOUS OR NONAUTOGENOUS, BY REPORT	$350
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES VIA A LATERAL OPEN APPROACH	$800
D7952	SINUS AUGMENTATION VIA A VERTICAL APPROACH	$350
D7960	FRENULECTOMY SEPARATE PROCEDURE	$105
D7963	FRENULOPLASTY	$105

ADA	DESCRIPTION	MEMBER PAYS
ORAL SURGERY SERVICES		
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$140
D7971	EXCISION OF PERICORONAL GINGIVA	$102
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$125
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$0
D9120	FIXED PARTIAL DENTURE SECTIONING	$0
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$0
D9211	REGIONAL BLOCK ANESTHESIA	$0
D9212	TRIGEMINAL DIVISION BLOCK ANES	$0
D9215	LOCAL ANESTHESIA	$0
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	$50
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$50
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$20
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$65
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$65
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$15
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$25
D9430	OV OBS - NO OTH SERVICES PERFORMED	$0
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$35
D9450	CASE PRSATION DTL & EXT TX PLANNING	$0
D9610	THERAPEUTIC DRUG INJECTION, BY REPORT	$15
D9630	DRUGS OR MEDICAMENTS DISPENSED IN THE OFFICE FOR HOME USE	$15
D9910	APPLICATION OF DESENSITIZING MEDICAMENT	$20
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9932	CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MAXILLARY	$0
D9933	CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MANDIBULAR	$0
D9934	CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MAXILLARY	$0
D9935	CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MANDIBULAR	$0
D9942	REPAIR AND/OR RELINE OCCCLUSAL GUARDS	$40
D9943	OCCLUSAL GUARD ADJUSTMENT	$25
D9950	OCCLUSAL ANALYSIS - MOUNTED CASE	$75
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$30
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$100
D9973	EXTERNAL BLEACHING - PER TOOTH	$30
D9975	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	$240
D9986	MISSED APPOINTMENT	$25
D9991	DENTAL CASE MANAGEMENT - ADDRESSING APPOINTMENT COMPLIANCE BARRIERS	$0
D9992	DENTAL CASE MANAGEMENT – CARE COORDINATION	$0
D9993	DENTAL CASE MANAGEMENT – MOTIVATIONAL INTERVIEWING	$0
D9994	DENTAL CASE MANAGEMENT – PATIENT EDUCATION TO IMPROVE ORAL HEALTH LITERACY	$0
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME ENCOUNTER	$0
D9996	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW	$0
D9997	DENTAL CASE MGMT-PATIENTS W/ SPECIAL NEEDS	$0
ORTHODONTIC SERVICES		
D8010	LTD ORTHO TREAT OF THE PRIMARY DENTITION	$1,000
D8020	LTD ORTHO TREAT OF THE TRANS DENTITION	$1,000
D8030	LTD ORTHO TREAT OF THE ADOLESC DENTITION	$1,000
D8040	LTD ORTHO TREAT OF THE ADULT DENTITION	$1,350
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$2,200
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$2,250
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$2,350
D8210	REMOVABLE APPLIANCE THERAPY	$103
D8220	FIXED APPLIANCE THERAPY	$103
D8660	PRE-ORTHODONTIC TREATMENT EXAM TO MONITOR GROWTH AND DEVELOPMENT	$35
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	$0
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	$300
D8681	REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT	$0
D8698	RECEM/REBOND FIXED RETAINER-MAXIL	$0
D8699	RECEM/REBOND FIXED RETAINER-MANDIB	$0
D8999c	c UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT	$250
FixedProsthedontics		
D5982	SURGICAL STENT	$150
D5987	COMMISSURE SPLINT	$150
D5988	SURGICAL SPLINT	$150

UnitedHealthcare/Select Managed Care dental exclusions and limitations

LIMITATIONS OF BENEFITS

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

1.	BITEWING RADIOGRAPHS	D0274, D0277 or D0210 are payable only when other inclusive image have not been taken (paid) within the la six (6) months. All Bitewing X-rays are limited to one set in any twelve (12) consecutive month period.
2.	SPACE MAINTAINERS	Space maintainers and all adjustments are limited to children under the age of 16.
3.	SEALANTS	Sealants (D1351 or D1352) are limited to one (1) time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.
4.	RESTORATIONS (Amalgam or Composite)	Fluoride treatment is limited to one (1) in any twelve (12) consecutive month period for children under the age of 16
5.	OCCLUSAL GUARDS	Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
6.	GENERAL ANESTHESIA	General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary, and previously approved.
7.	ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS	All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are included as part of the initial insertion.
8.	ORAL EVALUATION	Any oral evaluation (excluding problem) is limited to One (1) time per consecutive six (6) months; Comprehensive exams can only be covered one (1) time per 36 months, if and only if patient is considered to be new or an established patient. All subsequent oral evaluations will be at a 25% reduction off the dentist's usual and customary fee without a frequency limitation.
9.	CROWNS, FIXED BRIDGES, AND IMPLANTS	When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of $30.00 per unit.
10.	THIRD-MOLAR ("WISDOM TEETH") EXTRACTIONS	Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.
11.	PROPHYLAXIS AND PERIODONTAL MAINTENANCE	The dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive six (6) month period. Any additional procedures will follow D1110 and D4910 Member copayments as listed in the Schedule of Benefits.
12.	HARMFUL HABIT APPLIANCES	Harmful habit appliances are limited to one (1) time per person under the age of 16.
13.	DENTURES	New dentures include one (1) reline within the first six (6) months.
14.	REPLACEMENT OF CROWNS, IMPLANTS, AND FIXED BRIDGES OR DENTURES	Replacement of crowns, implants, and fixed bridges or dentures is limited to one (1) time every consecutive five (5) years.
15.	COST OF MATERIAL AND LAB FEES	Copayments marked by '*' do not include the cost of material and laboratory fees. Additional cost to patient is as follows: - High noble metal (precious) up to $145.00- Titanium metal up to $120 (covered with proof of allergy to other metals)- Noble metal (semi-precious) up to $120.00- Predominantly base metal (non-precious) up to $55.00- Crown laboratory fees up to $155.00- Laboratory fees on dentures up to $225.00- Porcelain laboratory fees for D2610-D2644, D2929, D2961, D2962, D6600, D6601, D6608, and D6609 up to $65.00- Denture repair laboratory fees up to $50.00- All ceramic and/or porcelain crown material fees up to $155.00.
16.	X-RAYS	Copies of X-rays can be obtained for $2 per periapical image up to a maximum of $30. Panoramic X-ray can be obtained for a $15 fee.
17.	EMERGENCY TREATMENT	Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence.
18.	ORTHO	Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.
19.	RADIOGRAPHS	D0364-D0365 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.

EXCLUSIONS OF BENEFITS

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

1.	Dental Services that are not Necessary.
2.	Hospitalization or other facility charges.
3.	Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4.	Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose to improve physiological functioning of the involved part of the body.
5.	Any Dental Procedure not directly associated with dental disease.
6.	Any Dental Procedure not performed in a dental setting.
7.	Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

  This plan is underwritten by Solstice, Inc. Administered by Dental Benefit Providers, Inc.

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:

9.	Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
10.	Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
11.	Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
12.	Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
13.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
14.	Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
15.	Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
16.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
17.	Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
18.	Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
19.	Foreign Services are not Covered unless required as an Emergency.
20.	Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
21.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
22.	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.

