Exclusive Network Plan (DHMO Alternative) Covered dental services

	Non-orthodontics		Orthodontics	
	Network	Non-network	Network	Non-network
Individual annual deductible	No Deductible	Not Applicable	Not Applicable	No Coverage
Family annual deductible	No Deductible	Not Applicable	Not Applicable	No Coverage
Maximum (the sum of all network and non-network benefits will not exceed annual maximum)	No Annual Maximum	Not Applicable	Copay Applies	No Coverage
Annual deductible applies to preventive and diagnostic services	N/A			
Annual deductible applies to orthodontic services	N/A			
Orthodontic eligibility requirement	Adult and children			

Covered services	Network plan pays	Non-network plan pays	Benefit guidelines
Diagnostic services			
Periodic oral evaluation	$0 Copay	N/A	See certificate of coverage for all exclusions and limitations
Radiographs	$0 – $150 Copay	N/A	
Preventive services			
Prophylaxis (cleaning)	$0 - $15 Copay	N/A	See certificate of coverage for all exclusions and limitations
Fluoride treatment (preventive)	$0 - $5 Copay	N/A	
Sealants	$0 Copay	N/A	
Space maintainers	$0 - $10 Copay	N/A	
Basic services			
Restorations, amalgams or composite (anterior and posterior)	$0–$120 Copay	N/A	See certificate of coverage for all exclusions and limitations
Emergency treatment/general services	$0 Copay	N/A	
Extractions	$10 - $270 Copay	N/A	
Oral surgery (incl. surgical extractions)	$10 – $800 Copay	N/A	
Periodontics	$0 – $502 Copay	N/A	
Endodontics	$10 – $535 Copay	N/A	

continued

Covered services	Network plan pays	Non-network plan pays	Benefit guidelines
Major services			
Inlays/onlays/crowns	$10 – $350 Copay	N/A	See certificate of coverage for all exclusions and limitations
Dentures and removable prosthetics	$8 – $240 Copay	N/A	
Fixed partial dentures (bridges)	$35 – $225 Copay	N/A	
Implants	$36 – $3800 Copay	N/A	
Orthodontic services			
Comprehensive Orthodontic Treatment Adult/Children	$1,000 –$1,950 Copay	N/A	

SPECIALTY SERVICES

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

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

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

d) Should the services of a Network Specialty Dentist (NSD) (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist) be necessary, you may receive this care in either of two ways: (1) You may go directly to a NSD with no referral and receive a 25% reduction off the provider's Usual and Customary Fee; or (2) You may obtain prior written authorization and receive specialty treatment by an approved NSD at the listed Co-payments.

e) Should the services of an Orthodontist be necessary, you may receive care in either of two ways: (1) You may go directly to a NSD with no referral and receive a 25%reduction off the provider's Usual and Customary Fee; or (2) You may contact Member Services to locate your nearest participating Orthodontist who will perform covered services at the listed member Co-payment.

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

Have more questions?

Visit **myuhc.com** or call **1-866-660-7181,** TTY **711**

United Healthcare | ECHOSTAR

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 Benefits:

1.	BITEWING RADIOGRAPHS	D0274, D0277 or D0210 are payable only when other inclusive image have not been taken
2.	SPACE MAINTAINERS	Space maintainers and all adjustments are limited to children under the age of 16
3.	SEALANTS	Sealants (D1351 or D1353) 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 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
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 removable prostheses or fixed bridgework. Includes semi-precision or precision attachments assoc'd with partial dentures, crown, bridges
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.

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 – COMPREHENSIVE SERIES OF 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	$20
D0310	RADIOGRAPHS -SIALOGRAPHY	$150
D0320	TMJ - Including injection	$250
D0321	OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES	$150
D0322	TOMOGRAPHIC SURVEY	$150
D0330*	PANORAMIC RADIOGRAPHIC IMAGE	$35
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$75
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	$140
D0365*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$130
D0366*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$130
D0367*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$175
D0368*	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$130
D0369*	MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION	$180
D0370*	MAXILLOFACIAL ULTRASOUND CAPTURE AND INTERPRETATION	$160
D0371*	SIALOENDOSCOPY AND CAPTURE AND INTERPRETATION	$160
D0372	INTRAORAL TOMOSYNTHESIS–COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES	$0
D0373	INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE	$0
D0374	INTRAORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE	$4
D0380*	CONE BEAM CT IMAGE CAPTURE WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$140
D0381*	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$130
D0382*	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$130
D0383*	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF BOTH JAWS	$175
D0384*	CONE BEAM CT IMAGE CAPTURE FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$130
D0385*	MAXILLOFACIAL MRI IMAGE CAPTURE	$160
D0386*	MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	$160
D0387	INTRAORAL TOMOSYNTHESIS–COMPREHENSIVE SERIES OF RADIOGRAPHIC–IMAGE CAPTURE ONLY	$0
D0388	INTRAORAL TOMOSYNTHESIS–BITEWING RADIOGRAPHIC–IMAGE CAPTURE ONLY	$0
D0389	INTRAORAL TOMOSYNTHESIS–PERIAPICAL RADIOGRAPHIC–IMAGE CAPTURE ONLY	$4
D0393*	VIRTUAL TRTMT SIMULATION USING 3D IMAGE VOLUME OR SURFACE SCAN	$0
D0394*	DIGITAL SUBTRACTION OF IMAGES	$0

ADA	Description	MEMBER PAYS
D0395*	FUSION OF TWO OR MORE 3D IMAGES	$0
D0415	COLLECT MICROORGANISMS CULT & SENS	$0
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
D0701*	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	$35
D0702*	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	$75
D0703*	2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE INTRA-ORALLY OR EXTRA-ORALLY–IMAGE CAPTURE ONLY	$20
D0705*	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0706*	INTRAORAL–OCCLUSAL RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0707*	INTRAORAL–PERIAPICAL RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	$2
D0708*	INTRAORAL–BITEWING RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0709*	INTRAORAL–COMPREHENSIVE SERIES OF RADIOGRAPHIC–IMAGE CAPTURE ONLY	$0
D0801	3D DENTAL SURFACE SCAN – DIRECT	$0
D0802	3D DENTAL SURFACE SCAN – INDIRECT	$0
D0803	3D FACIAL SURFACE SCAN – DIRECT	$0
D0804	3D FACIAL SURFACE SCAN – INDIRECT	$0
PREVENTIVE SERVICES		
D1110*	PROPHYLAXIS - ADULT	$0
D1110*	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	$15
D1120*	PROPHYLAXIS - CHILD	$0
D1120*	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6 MONTHS	$15
D1206*	TOPICALFLUORIDE VARNISH	$5
D1208*	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$0
D1301	IMMUNIZATION COUNSELING	$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*	APPLICATION OF CARIES ARRESTING MEDICAMENT–PER TOOTH	$20
D1355	CARIES PREVENTIVE MEDICAMENT APPLICATION – PER TOOTH	$20
D1510*	SPACE MAINTAINER - FIXED, UNILATERAL/QUAD	$0
D1516*	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	$0
D1517*	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	$0
D1520*	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	$0
D1526*	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	$0
D1527*	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	$0
D1551	RECEM/REBOND BILATERAL SPACE MAINTAINER – MAXIL	$10
D1552	RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB	$10
D1553	RECEM/REBOND UNILATERAL SPACE MAINTAINER/QUAD	$10

ADA	Description	MEMBER PAYS
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER/QUAD	$10
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	$10
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	$10
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	$20
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	$32
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	$40
D2335	RESIN-BASED COMPOSITE – FOUR OR MORE SURFACES (ANTERIOR)	$70
D2390	RESIN COMPOSITE CROWN ANTERIOR	$100
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	$45
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	$65
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	$80
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	$95
D2410	GOLD FOIL - ONE SURFACE	$65
D2420	GOLD FOIL - TWO SURFACES	$90
D2430	GOLD FOIL - THREE SURFACES	$120
D2510	INLAY - METALLIC - ONE SURFACE	$80
D2520	INLAY - METALLIC - TWO SURFACES	$90
D2530	INLAY - METALLIC - 3/MORE SURFACES	$115
D2542	ONLAY - METALLIC - TWO SURFACES	$250
D2543	ONLAY - METALLIC THREE SURFACES	$270
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	$290
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	$225*
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$250*
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	$275*
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$310*
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	$340*
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	$350*
D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	$180
D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	$200
D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	$250
D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	$225
D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	$245
D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	$275
D2710*	CROWN - RESIN - BASED COMPOSITE INDIRECT	$195
D2712*	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	$195
D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	$195*
D2721*	CROWN - RESIN W/PREDOM BASE METAL	$195*
D2722*	CROWN - RESIN WITH NOBLE METAL	$195*
D2740*	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$195*
D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	$195*
D2751*	CROWN - PORCELAIN FUSED PREDOM BASE METAL	$195*
D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	$195*
D2753*	CROWN PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$195*
D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	$195*
D2781*	CROWN - 3/4 CAST PREDOM BASE METAL	$195*
D2782*	CROWN - 3/4 CAST NOBLE METAL	$195*
D2783*	CROWN - 3/4 PORCELAIN/CERAMIC	$195*
D2790*	CROWN - FULL CAST HIGH NOBLE METAL	$195*

ADA	Description	MEMBER PAYS
D2791*	CROWN - FULL CAST PREDOM BASE METAL	$195*
D2792*	CROWN - FULL CAST NOBLE METAL	$195*
D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	$195*
D2799*	INTERIM CROWN–FURTHER TRTMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	$125
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$10
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFABRICATED POST & CORE	$10
D2920	RECEMENT OR RE-BOND CROWN	$10
D2921	REATTACHMENT OF TOOTH FRAGMENT	$10
D2928*	PREFABRICATED PORCELAIN/CERAMIC CROWN – PERMANENT TOOTH	$34*
D2929*	PREFABRICATED PORCELAIN CROWN- PRIMARY	$34*
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	$35
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	$40
D2932	PREFABRICATED RESIN CROWN	$90
D2933	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	$135
D2940	SEDATIVE FILLING	$5
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$5
D2949	RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION	$20
D2950	CORE BUILDUP INCLUDING ANY PINS	$35
D2951	PIN RETENTION - PER TOOTH ADDITION REST	$10
D2952	POST & CORE ADD CROWN INDIRECT FAB	$80
D2953	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	$95
D2954	PREFABRICATED POST & CORE ADDITION CROWN	$75
D2955	POST REMOVAL	$20
D2957	EACH ADD PREFABR POST - SAME TOOTH	$30
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	$200
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	$225*
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	$350*
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER XST PART DENTURE	$45
D2975	COPING	$95
D2980	CROWN REPAIR	$95
D2981	INLAY REPAIR	$95
D2982	ONLAY REPAIR	$95
D2983	VENEER REPAIR	$95
D2989	EXCAVATION OF TOOTH RESULT IN DETERMINATION OF NON-RESTORABILITY	$125
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$29
D2991	APPLICATION OF HYDROXYAPATITE REGEN MEDICAMENT–PER TOOTH	$0
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$10
D3120	PULP CAP - INDIRECT	$10
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL JUNC	$20
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT TEETH	$95
D3222	PARTIAL PULPOTOMY	$75
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$40
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$40
D3310	ANTERIOR	$100
D3320	BICUSPID	$175
D3330	MOLAR	$210
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	$250
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$285
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$350
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	$90

ADA	Description	MEMBER PAYS
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	$90
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$90
D3410	APICOECTOMY SURG - ANT	$96
D3421	APICOECTOMY SURG-BICUSPID	$300
D3425	APICOECTOMY SURG - MOLAR	$150
D3426	APICOECTOMY SURGERY	$75
D3428	BONE GRAFT WITH PERIRADICULAR SURGERY PER TOOTH	$32
D3429	BONE GRAFT WITH PERIRADICULAR SURGERY EACH ADDITIONAL TOOTH	$25
D3430	RETROGRADE FILLING - PER ROOT	$55
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	$85
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$535
D3470	INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING)	$175
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	$96
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR	$300
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	$150
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR	$96
D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–PREMOLAR	$96
D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–MOLAR	$96
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$95
D3920	HEMISECTION NOT INCL RC THERAPY	$80
D3921	DECORONATION OR SUBMERGENCE OF AN ERUPTED TOOTH	$25
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	$66
D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST PROC/TOOTH	$40
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$163
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$150
D4245	APICALLY POSITIONED FLAP	$150
D4249	CLIN CROWN LEN - HARD TISSUE	$175
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 SOFT AND OSSEOUS TISSUE REGEN, PER SITE	$82
D4266	GUIDED TISSUE REGEN, NATURAL TEETH–RESORBABLE BARRIER, PER SITE	$325
D4267	GUIDED TISSUE REGEN, NATURAL TEETH–NON-RESORBABLE BARRIER, PER SITE	$325
D4268	SURGICAL REVISION PROCEDURE, PER TOOTH	$0
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$235
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$280
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$100
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$502
D4276	COMBINED CONNECTIVE TISSUE AND PEDICLE GRAFT, PER TOOTH	$65
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$215
D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH	$75
D4283	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	$250
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
D4286	REMOVAL OF NON-RESORBABLE BARRIER	$20
D4322	SPLINT–INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	$100
D4323	SPLINT–EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	$100
D4341*	PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD	$36t

ADA	Description	MEMBER PAYS
D4342*	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	$29t
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$35
D4355*	FULL MOUTH DEBRID COMP PERIODONTAL EVAL & DX	$35t
D4381*	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$45t
D4910*	PERIODONTAL MAINTENANCE	$40
D4920	UNSCHEDULED DRESSING CHANGE	$20
D4921	GINGIVAL IRRIGATION WITH A MEDICINAL AGENT–PER QUAD	$15
D4999	UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT	$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110*	COMPLETE DENTURE - MAXILLARY	$210*
D5120*	COMPLETE DENTURE - MANDIBULAR	$210*
D5130*	IMMEDIATE DENTURE - MAXILLARY	$210*
D5140*	IMMEDIATE DENTURE - MANDIBULAR	$210*
D5211*	MAXILLARY PARTIAL DENTURE - RESIN BASE	$210*
D5212*	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$210*
D5213*	MAX PART DENTUR-CAST METL W/RSN	$220*
D5214*	MAND PART DENTUR- CAST METL W/RSN	$220*
D5221*	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$230*
D5222*	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$230*
D5223*	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$240*
D5224*	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$240*
D5225*	MAXILLARY PARTIAL DENTURE FLEX BASE	$220*
D5226*	MANDIBULAR PARTIAL DENTURE FLEX BASE	$220*
D5227*	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX BASE	$230*
D5228*	IMMEDIATE MANDIBULAR PARTIAL DENTURE-FLEX BASE	$230*
D5282*	REMOVABLE UNILATERAL PARTIAL DENTURE - MAXILLARY	$235*
D5283*	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	$235*
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$8
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$8
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$10
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$10
D5511*	REPAIR BROKEN COMPLETE DENTURE BASE	$15*
D5512*	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$15*
D5520*	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$10*
D5611*	REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	$15*
D5612*	REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	$15*
D5621*	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$30*
D5622*	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$30*
D5630*	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$15*
D5640*	REPLACE BROKEN TEETH - PER TOOTH	$10*
D5650*	ADD TOOTH EXISTING PARTIAL DENTURE	$30*
D5660*	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$30*
D5670*	REPLACE ALL TEETH & ACRYLC FRMEWRK MAXILLARY	$100*
D5671*	REPLACE ALL TEETH & ACRYLC FRMEWRK MANDIBULAR	$100*
D5710*	REBASE COMPLETE MAXILLARY DENTURE	$75*
D5711*	REBASE COMPLETE MANDIBULAR DENTURE	$75*
D5720*	REBASE MAXILLARY PARTIAL DENTURE	$75*
D5721*	REBASE MANDIBULAR PARTIAL DENTURE	$75*
D5725*	REBASE HYBRID PROSTHESIS	$75*
D5730*	RELINE CMPL MAXIL DENTURE (DIRECT)	$45*
D5731*	RELINE CMPL MAND DENTURE (DIRECT)	$45*
D5740*	RELINE MAXIL PART DENTURE (DIRECT)	$45*

ADA	Description	MEMBER PAYS
D5741*	RELINE MAND PART DENTURE (DIRECT)	$45*
D5750*	RELINE CMPL MAXIL DENTURE (INDIRECT)	$35*
D5751*	RELINE CMPL MAND DENTURE (INDIRECT)	$35*
D5760*	RELINE MAXIL PART DENTURE (INDIRECT)	$35*
D5761*	RELINE MAND PART DENTURE (INDIRECT)	$35*
D5765*	SOFT LINER FOR COMPLETE OR PART REMOVABLE DENTURE–INDIRECT	$69
D5810*	INTERIM COMPLETE DENTURE (MAXILLARY)	$220*
D5811*	INTERIM COMPLETE DENTURE (MANDIBULAR)	$220*
D5820*	INTERIM PARTIAL DENTURE MAXILLARY	$220*
D5821*	INTERIM PARTIAL DENTURE MANDIBULAR	$220*
D5850	TISSUE CONDITIONING MAXILLARY	$25
D5851	TISSUE CONDITIONING MANDIBULAR	$25
D5862	PRECISION ATTACHMENT, BY REPORT	$150
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT	$0
IMPLANT SERVICES		
D6010*	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$950
D6012*	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT	$950
D6056*	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$385
D6057*	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$495
D6058*	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$695
D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$695
D6060*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$695
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$695
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$695
D6063*	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$695
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$695
D6065*	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$695
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$695
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	$695
D6068*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$695
D6069*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$695
D6070*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$695
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$695
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$695
D6073*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$695
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$695
D6075*	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$695
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$695
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	$695
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	$36t
D6082*	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$695
D6083*	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS	$695
D6084*	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$695
D6085	INTERIM IMPLANT CROWN	$125
D6086*	IMPLANT SUPPT CROWN-PREDOM. BASE ALLOYS	$695
D6087*	IMPLANT SUPPT CROWN-NOBLE ALLOYS	$695
D6088*	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM ALLOYS	$695
D6089	ACCESSING AND RETORQUING LOOSE IMPLANT SCREW - PER SCREW	$50
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	$695

ADA	Description	MEMBER PAYS
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$220
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$500
D6097*	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$695
D6098*	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$695
D6099*	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	$695
D6100	SURGICAL REMOVAL OF IMPLANT BODY	$700
D6105	REMVL OF IMPLANT BODY NOT REQUIR BONE REMVL/FLAP ELEVATION	$700
D6106	GUIDED TISSUE REGEN–RESORBABLE BARRIER, PER IMPLANT	$325
D6107	GUIDED TISSUE REGEN–NON-RESORBABLE BARRIER, PER IMPLANT	$325
D6110*	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$1200
D6111*	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$1200
D6112*	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$940
D6113*	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$940
D6114*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$3800
D6115*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$3800
D6116*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$2200
D6117*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$2200
D6118*	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$1760
D6119*	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$1760
D6120*	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$695
D6121*	IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS	$695
D6122*	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	$695
D6123*	IMPLANT SUPPT RETAINER FOR METAL FPD-TITANIUM/TITANIUM ALLOYS	$695
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$235
D6198	REMOVE INTERIM IMPLANT COMPONENT	$700
FIXED PROSTHODONTIC SERVICES		
D6205*	PONTIC- INDIRECT RESIN BASED COMPOSITE	$695
D6210*	PONTIC - CAST HIGH NOBLE METAL	$195*
D6211*	PONTIC - CAST PREDOM BASE METAL	$195*
D6212*	PONTIC - CAST NOBLE METAL	$195*
D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	$195*
D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	$195*
D6241*	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	$195*
D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	$195*
D6243*	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$195*
D6245*	PONTIC - PORCELAIN/CERAMIC	$195*
D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	$195*
D6251*	PONTIC RESIN W/PREDOM BASE METAL	$195*
D6252*	PONTIC RESIN W/NOBLE METAL	$195*
D6253*	INTERIM PONTIC–FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	$0
D6545	RETAINER - CASE METAL FOR RESIN FIXED PROSTHESIS	$180
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	$225*
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2 SURFACES	$195*
D6601	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$195*
D6602	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	$195*
D6603	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	$195*
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	$195*
D6605	RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES	$195*
D6606	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$195*
D6607	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	$195*
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	$195*
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$195*
D6610	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	$195*
D6611	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	$195*

ADA	Description	MEMBER PAYS
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	$195*
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	$195*
D6614	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$195*
D6615	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	$195*
D6624	RETAINER INLAY - TITANIUM	$195*
D6634	RETAINER ONLAY - TITANIUM	$195*
D6710*	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$195*
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$195*
D6721*	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$195*
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	$195*
D6740*	RETAINER CROWN - PORCELAIN/CERAMIC	$195*
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$195*
D6751*	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$195*
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$195*
D6753*	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$195*
D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$195*
D6781*	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$195*
D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	$195*
D6783*	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$195*
D6784*	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	$195*
D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$195*
D6791*	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$195*
D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	$195*
D6793*	INTERIM RETAINER CROWN–FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	$125
D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	$195*
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$10
D6940	STRESS BREAKER	$125
D6950	PRECISION ATTACHMENT	$125
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$80
ORAL SURGERY SERVICES		
D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	$45
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$10
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$25
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$40
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$55
D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	$63
D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	$100
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$25
D7251	CORONECTOMY–INTENTIONAL PART TOOTH REMVL, IMPACT TEETH ONLY	$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	$115
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$60
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$50
D7288	BRUSH BIOPSY	$25
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	$30
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$20
D7311	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	$20

ADA	Description	MEMBER PAYS
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$50
D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	$50
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
D7509	MARSUPIALIZATION OF ODONTOGENIC CYST	$65
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
D7956	GUIDED TISSUE REGEN, EDENTULOUS AREA–RESORBABLE BARRIER, PER SITE	$325
D7957	GUIDED TISSUE REGEN, EDENTULOUS AREA–NON-RESORBABLE BARRIER, PER SITE	$325
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	$50
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	$50
D7963	FRENULOPLASTY	$50
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$140
D7971	EXCISION OF PERICORONAL GINGIVA	$102
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$125
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATIVE TREATMENT OF DENTAL PAIN – PER VISIT	$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	$25
D9450	CASE PRSATION SUBSEQUENT TO 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
D9912	PRE-VISIT PATIENT SCREENING	$0
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9932	CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MAXILLARY	$0

ADA	Description	MEMBER PAYS
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
D9944*	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	$250
D9945*	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	$250
D9946*	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH	$250
D9947	CUSTOM SLEEP APNEA APPLIANCE FABRICATION AND PLACEMENT	$1900
D9948	ADJUSTMENT OF CUSTOM SLEEP APNEA APPLIANCE	$85
D9949	REPAIR OF CUSTOM SLEEP APNEA APPLIANCE	$88
D9950	OCCLUSAL ANALYSIS - MOUNTED CASE	$75
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$25
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$75
D9953	RELINE CUSTOM SLEEP APNEA APPLIANCE (INDIRECT)	$45
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	$1000
D8020	LTD ORTHO TREAT OF THE TRANS DENTITION	$1000
D8030#	LTD ORTHO TREAT OF THE ADOLESC DENTITION	$1000
D8040#	LTD ORTHO TREAT OF THE ADULT DENTITION	$1350
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$1800
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$1850
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$1950
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	$100*
D5987	COMMISSURE SPLINT	$100*
D5988	SURGICAL SPLINT	$100*

Additional Prophy within 6 months will be based upon the necessity recommended by the provider.
Procedure descriptions preceded with a "*" have a limitation, please see limitations below for details.
Copayment amounts with a "*" have a lab and/or materials fee in addition to the copayment amount, please see Limitations below for details.
Services with a 't' are not eligible at a Specialist.
Self-service aligners are available for a member copayment of $1000.
For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.

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 Benefits:

1.	BITEWING RADIOGRAPHS	D0274, D0277 or D0210 are payable only when other inclusive image have not been taken
2.	SPACE MAINTAINERS	Space maintainers and all adjustments are limited to children under the age of 16.
3.	SEALANTS	Sealants (D1351 or D1353) 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 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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

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
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.