

Welcome

to your California Select Managed
Care Direct Compensation dental plan



Welcome to the California Select Managed Care Direct Compensation plan from UnitedHealthcare Dental.* We'll do everything we can to make your experience a positive one.

Take a few minutes to review this information, and remember that we're here to help if you have questions. Simply call Customer Care at the number on your ID card.

Your plan provides comprehensive benefits.

This plan provides terrific benefits. Your coverage begins right away, and you do not need to meet a deductible (an amount members sometimes must pay before receiving coverage). There is also no limit on how much the plan will pay in a given year, and the plan does not exclude care for dental issues you may have had before becoming a UnitedHealthcare dental member.

What's covered?

Preventive care — Your plan will pay for all or most of your preventive dental care needs, which include your routine checkups and cleanings. Generally speaking, you are limited to two cleanings in a 12-month period. However, some plans cover more cleanings for an additional copay. Check your plan information on myuhc.com, or give us a call and we will review your benefits with you. Note this plan covers annual oral cancer screens for adults as well.

Fillings, crowns and more — For services other than preventive care, you will pay a copay (a set dollar amount) to your dental office, generally at the time of your service. Your member website will outline your copays, or give us a call and we will review them with you.

Your plan covers other types of care, such as fillings and crowns, as well as orthodontia (braces.) However, some services that are done to improve the look of your teeth, such as teeth whitening, may not be covered by your plan.

Five things to know:

1. You may see any primary care (general) dentist who is part of the network. That dentist will provide most of your care. If you need to see a specialist, your primary care dentist will give you a referral. Some plans do not offer any coverage if you see a dentist who is not part of the network. Check your plan documents or call Customer Care to see how your plan works.
2. You can locate a primary care dentist who is part of the network by using the Find a Dentist tool on myuhc.com or by calling Customer Care at the number on your ID card.
3. Your plan fully covers most preventive care. You'll pay a copay at the time of your visit for other types of care, including orthodontia (braces).
4. There's a website just for you — myuhc.com.
5. Call us at the number on your ID card any time you have a question.



Your ID card:

- You can print your ID card from **myuhc.com**.
- If you are a new member, you will be issued a card. If you are not, continue to use the one you have.
- Your ID card only lists the name of the person who signed up for the plan, but all of those covered by your plan should use this card.
- Bring your dental ID card with you each time you see the dentist.

White or silver fillings? — If you choose to have white fillings (known as resin-based composite) in your back teeth, you may have to pay a higher copay than for silver fillings.

Extra services covered if you're pregnant

If you are pregnant, your plan covers extra visits for cleanings and gum treatments as recommended by your dentist. (Check your plan document for details.) Be sure to take advantage of this benefit because during pregnancy women can have increased levels of bacteria in the mouth which can lead to tooth decay. Ask your dentist to submit a paper claim to the claims address on your ID card, including the name of your obstetrician and your pregnancy due date, and we'll take care of the rest.

Finding a dentist in the network

To find a dentist in your network, log in to **myuhc.com**. That way, you'll only see your plan's network. If you decide not to log in, you can still use the online Find a Dentist tool, but you'll have to select your network from a list of networks, which is an added step.

Customer Care can also help you find a dentist in the network. Call the number on your ID card.

Questions?

If you have questions about your benefits, visit **myuhc.com** or call Customer Care. Thank you again for choosing UnitedHealthcare. You're on your way to a healthy, beautiful smile!



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

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.

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Dental

Welcome to myuhc.com—your dental member website

Your dental member website—**myuhc.com**—offers lots of information and easy to use tools to help you get the most from your dental plan. (If you used myuhcdental.com in the past, you will now use myuhc.com.)

Getting started

You'll have to register to use myuhc.com. Visit **myuhc.com** and click "Register Now." You'll need your dental ID card to register, or your Social Security number and date of birth. If you need help, call Customer Care at the number on your ID card.

Key online features

With **myuhc.com**, you'll be able to:

- ▶ Print a dental ID card.
- ▶ View an Explanation of Benefits (EOB) to find out what the plan will pay and what you will pay.
- ▶ Easily find a dentist. Get Google® driving directions to the dental office.
- ▶ View much of the site in Spanish.
- ▶ View much of the site on a smartphone.



Once you log in, you'll find all the site's most popular features right on the home page.

- 1 **Health and Wellness** Learn about oral care and how oral health impacts overall health.
- 2 **Manage My Claims** View claim history and Explanation of Benefits.
- 3 **Look Up My Benefits** View your benefit summary and see what is covered by your plan.
- 4 **Find a Dentist** Find a dentist nearby who is in the network.¹
- 5 **Print an ID Card** Print a dental ID card for you and your family.²
- 6 **Dental Cost Calculator** Find out what your plan will pay for a procedure and what you will have to pay. Compare fees of dentists in your area.³

Shopping for dental care

The Dental Cost Calculator tells you what your plan will pay and what you will have to pay for each type of service. Compare costs of dentists in your area and save. The Dental Cost Calculator is available with most plans.³

Learning about oral health

Taking good care of your teeth and gums is not just important for your oral health—it plays a role in your overall health. Visit the “Health and Wellness” tab for information that will help keep your smile beautiful and healthy.



Questions?

Call the number on your dental ID card.



¹Not all plans have networks.

²Your ID card will only list the subscriber's name but is valid for all covered members.

³Dental Cost Calculator is available with most plans except Select DHMO or Direct Compensation plans.

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Dental

Features and benefits

Online Provider Directories

▶ Find us on the web at: myuhc.com

▶ On the right hand side of the page click on "Find a Dentist"

myClaims Manager
 Managing your claims just got easier – **now with online bill payment.**
 Learn More

May not be available with all plans.

PLAN DISCOUNTS | YOUR PLAN PAID | YOUR RESPONSIBILITY | MAKE ONLINE PAYMENTS

1 2 3 4 5

Information Center
 Learn More About

- UnitedHealth Premium® Designated Physicians
- Health Insurance for those not covered by employer
- Dental Plans for those not covered under an employer's plan
- Short Term Health Insurance
- Health Savings Account
- Flexible Spending Account
- Commuter Expense Reimbursement Account
- Medical & Reimbursement Policies

Links and Tools

- Find Physician, Laboratory or Facility
- Find a Dentist
- Pharmacy Information
- Find a Form
- Find Mental Health Clinician
- Estimate Health Plan Costs

Common Questions

- What browsers are supported?
- What are the benefits of registering and having a username and password?
- How do I register?
- Do I need to re-register if my group number changes?
- What if I don't have my ID card?
- Is this website secure?
- What accreditations and certifications has UnitedHealthcare received?

Related Web Sites

- uhclatino
- uhclatino mobile

- ▶ Select your state
- ▶ Select "CA Select Managed Care Direct Compensation"

Find a Dentist

En Español

To ensure you receive the most accurate listing of Dental Providers within your Network, please register with the site. As a non-registered user, please select from the Dental Provider Networks listed.

[Start New Search](#)

Where do you work or live?

Select a Network

- *GOVT EMPLOYEES VOL BENEFIT TRUST
- *MEDICARE AND RETIREMENT PLAN NATIONAL NETWORK
- *MEDICARE COMMUNITY PLAN NATIONAL NETWORK
- *NATIONAL OPTIONS PPO 10
- *NATIONAL OPTIONS PPO 20
- *NATIONAL OPTIONS PPO 30
- CA DHMO AARP MEDICARE COMPLETE
- CA DHMO LEGACY PACIFICARE
- CA DHMO PEDIATRIC EHB & FAMILY BUY UP
- CA DIRECT COMPENSATION PACIFIC UNION
- CA SELECT MANAGED CARE DHMO PLAN
- CA SELECT MANAGED CARE DIRECT COMPENSATION
- CT MEDICARE ONLY

Search for Dentist

[View additional Do](#)

Please note: as the list you see on this site may not be the same for informational purposes only.

If you would like to search for dentists as a registered user, please [log in](#) or [register](#).

- ▶ Select the type of search
 - Location, dentist name, or practice name
- ▶ The online directory includes all network providers. The following provider information is available:
 - Provider Name, Address, and Telephone Number
 - Provider's ID Number
 - Office Language Capabilities
 - Office Hours
- ▶ Print, email or export the list of providers in your area
- ▶ Google Maps® directions available to dentist office.



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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 - PROB FOCUS RPT	\$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	\$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	\$0
D0190	SCREENING OF A PATIENT	\$5
D0191	ASSESSMENT OF A PATIENT	\$5
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	\$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	\$0
D0230	INTRAORAL PERIAPICAL EA ADD RADIOGRAPHIC IMAGE	\$0
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	\$0
D0260	EXTRAORAL - EACH ADDITIONAL RADIOGRAPHIC IMAGE	\$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	\$0
D0290	POST-ANT OR LATERAL SKULL AND FACIAL SURVEY IMAGE	\$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT ANALYSIS	\$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$5
D0415	COLLECT MICROORGANISMS CULT & SENS	\$0
D0416	Viral Culture	\$0
D0417	COLLECTION AND PREP OF SALIVA	\$0
D0418	ANALYSIS OF SALIVA SAMPLE	\$0
D0421	Genetic Test for Susceptibility to Oral Disease	\$0
D0425	CARIES SUSCEPTIBILITY TESTS	\$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	\$0
D0460	PULP VITALITY TESTS	\$0
D0470	DIAGNOSTIC CASTS	\$0
D0472	ACCESS TISS-GROSS EXAM-PREP & REPRT	\$0
D0473	ACCESS TISS-GROSS/MICRO-PREP/REPRT	\$0
D0474	ACSS TISS GR&MIC SURG MARG PREP/RPT	\$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
D1120	PROPHYLAXIS - CHILD	\$0
D1206	TOP FLUORIDE VARNISH	\$0
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	\$5
D1352	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOT	\$0
D1510	SPACE MAINTAINER - FIXED-UNILATERAL	\$0
D1515	SPACE MAINTAINER - FIXED-BILATERAL	\$0
D1520	SPACE MAINTAINER - REMOVABLE-UNI	\$0
D1525	SPACE MAINTAINER - REMOVABLE-BIL	\$0

ADA	DESCRIPTION	MEMBER PAYS
D1550	RECEMENT OR RE-BOND SPACE MAINTAINER	\$0
D1555	REMOVAL OF FIXED SPACE MAINTAINER	\$0
RESTORATIVE SERVICES		
D2140	AMALGAM-ONE SURFACE PRIMARY/PERM	\$0
D2150	AMALGAM-TWO SURFACES PRIMARY/PERM	\$0
D2160	AMALGAM-3 SURFACES PRIMARY/PERM	\$0
D2161	AMALGAM-FOUR/MORE SURF PRIM/PERM	\$0
D2330	RESIN COMPOS - ONE SURFACE ANTERIOR	\$0
D2331	RESIN COMPOS - 2 SURFACES ANTERIOR	\$0
D2332	RESIN COMPOS - 3 SURFACES ANTERIOR	\$0
D2335	RSN COMPOS-4/> SURF/W/INCISAL ANG	\$0
D2390	RESIN COMPOS CROWN ANTERIOR	\$20
D2391	RESIN COMPOS - 1 SURFACE POSTERIOR	\$5
D2392	RESIN COMPOS - 2 SURFACES POSTERIOR	\$10
D2393	RESIN COMPOS - 3 SURFACES POSTERIOR	\$10
D2394	RESIN COMPOS - 4/MORE SURFACES POST	\$10
D2510	INLAY - METALLIC - ONE SURFACE	\$95
D2520	INLAY - METALLIC - TWO SURFACES	\$95
D2530	INLAY - METALLIC - 3/MORE SURFACES	\$95
D2542	ONLAY - METALLIC - TWO SURFACES	\$95
D2543	ONLAY METALLIC THREE SURFACES	\$95
D2544	ONLAY METALLIC FOUR OR MORE SURF	\$95
D2610	INLAY - PORCELN/CERAMIC - 1 SURFACE	\$35
D2620	INLAY - PORCELN/CERAMIC - 2 SURF	\$40
D2630	INLAY - PORCELN/CERAM - 3/MORE SURF	\$45
D2642	ONLAY - PORCELN/CERAMIC - 2 SURF	\$95
D2643	ONLAY - PORCELN/CERAMIC - 3 SURF	\$95
D2644	ONLAY - PORCELN/CERAM - 4/MORE SURF	\$95
D2650	INLAY-RSN COMPOS COMPOS/RSN-1 SURF	\$30
D2651	INLAY-RSN COMPOS COMPOS/RSN-2 SURF	\$35
D2652	INLAY-RSN COMPOS COMPOS/RSN-3/>SURF	\$40
D2662	ONLAY-RSN COMPOS COMPOS/RSN-2 SURF	\$30
D2663	ONLAY-RSN COMPOS COMPOS/RSN-3 SURF	\$40
D2664	ONLAY-RSN COMPOS COMPOS/RSN-4/>	\$45
D2710	CROWN RESINBASED COMPOSITE INDIRECT	\$42
D2712	CROWN 3/4 RESNBASED COMPOS INDIRECT	\$42
D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	\$59
D2721	CROWN - RESIN W/PREDOM BASE METAL	\$60
D2722*	CROWN - RESIN WITH NOBLE METAL	\$63
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	\$66
D2750*	CROWN - PORCELN FUSED HI NOBLE METL	\$73
D2751	CROWN-PORCELN FUSD PREDOM BASE METL	\$66
D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	\$70
D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	\$73
D2781	CROWN - 3/4 CAST PREDOM BASE METL	\$64
D2782*	CROWN - 3/4 CAST NOBLE METAL	\$69
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	\$66
D2790*	CROWN - FULL CAST HIGH NOBLE METAL	\$73
D2791	CROWN - FULL CAST PREDOM BASE METL	\$64
D2792*	CROWN - FULL CAST NOBLE METAL	\$69
D2794*	CROWN TITANIUM	\$73
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	\$6
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFAB POST & CORE	\$6
D2920	RECEMENT OR RE-BOND CROWN	\$7
D2921	REATTACHMENT OF TOOTH FRAGMENT	\$5
D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	\$10
D2930	PRFABR STAINLESS STEEL CROWN-PRIM	\$14

ADA	DESCRIPTION	MEMBER PAYS
D2931	PRFABR STAINLESS STEEL CROWN-PERM	\$17
D2932	PREFABRICATED RESIN CROWN	\$14
D2933	PRFABR STNLSS STEEL CROWN RSN WNDOW	\$10
D2934	PREFAB ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	\$14
D2940	SEDATIVE FILLING	\$0
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	\$5
D2950	CORE BUILDUP INCLUDING ANY PINS	\$14
D2951	PIN RETN - PER TOOTH ADDITION REST	\$6
D2952	POST & CORE ADD CROWN INDIRECT FAB	\$22
D2953	EA ADD INDIRECT FAB POST SAME TOOTH	\$6
D2954	PREFABR POST&CORE ADDITION CROWN	\$16
D2955	POST REMOVAL	\$20
D2957	EA ADD PREFABR POST - SAME TOOTH	\$4
D2960	LABIAL VENEER (LAMINATE) - CHAIRSIDE	\$20
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	\$40
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	\$40
D2970	TEMPORARY CROWN	\$14
D2971	ADD PROC NEW CROWN XST PART DENTURE	\$10
D2975	COPING	\$70
D2980	CROWN REPAIR	\$15
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	\$5
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	\$0
D3120	PULP CAP - INDIRECT	\$0
D3220	TX PULPOT-CORONL DENTNOCEMENTL JUNC	\$0
D3221	PULPAL DEBRID PRIMARY&PERM TEETH	\$0
D3222	PARTIAL PULPOTOMY	\$0
D3230	PULPAL THERAPY - ANT PRIMARY TOOTH	\$0
D3240	PULPAL THERAPY - POST PRIMARY TOOTH	\$0
D3310	ANTERIOR	\$0
D3320	BICUSPID	\$0
D3330	MOLAR	\$60
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	\$5
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	\$0
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	\$5
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	\$0
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	\$0
D3348	RETX PREVIOUS RC THERAPY - MOLAR	\$60
D3351	APEXIFICAT/RECALCIFICAT - INIT VST	\$9
D3352	APEXIFICAT/RECALCIFICAT-INTERIM	\$5
D3353	APEXIFICAT/RECALCIFICAT-FINAL VISIT	\$10
D3355	PULPAL REGENERATION - INITIAL VISIT	\$5
D3356	PULPAL REGENERATION -INTERIM MEDICAMENT REPLACEMENT	\$5
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	\$10
D3410	APICOECTOMY SURG - ANT	\$32
D3421	APICOECTOMY SURG-BICUSPID	\$64
D3425	APICOECTOMY SURG - MOLAR	\$96
D3426	APICOECTOMY SURGERY	\$50
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	\$10
D3430	RETROGRADE FILLING - PER ROOT	\$50
D3450	ROOT AMPUTATION - PER ROOT	\$23
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$1,950
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	\$5
D3920	HEMISECTION NOT INCL RC THERAPY	\$21
D3950	CANAL PREP&FIT PREFORMED DOWEL/POST	\$5
PERIODONTIC SERVICES		
D4210	GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	\$0
D4211	GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	\$0

ADA	DESCRIPTION	MEMBER PAYS
D4212	GINGIVECT/PLSTY WITH REST PROC/TOOTH	\$0
D4240	INGL FLP 4/>CNTIG/BOUND TEETH QUAD	\$0
D4241	INGL FLP 1-3 CNTIG/BN D TEETH QUAD	\$0
D4245	APICALLY POSITIONED FLAP	\$10
D4249	CLIN CROWN LEN - HARD TISSUE	\$10
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	\$56
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	\$37
D4263	BONE REPLCMT GRAFT - 1 SITE QUAD	\$66
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$61
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	\$0
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	\$15
D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH	\$5
D4320	PROVISIONAL SPLINTING - INTRACORONAL	\$10
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	\$10
D4341	PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	\$0
D4342	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	\$0
D4355	FULL MOUTH DEBRID COMP EVAL&DX	\$5
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEA VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	\$5
D4910	PERIODONTAL MAINTENANCE	\$0
D4920	UNSCHEDULED DRESSING CHANGE	\$0
D4921	GINGIVAL IRRIGATION - PER QUADRANT	\$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110	COMPLETE DENTURE - MAXILLARY	\$93
D5120	COMPLETE DENTURE - MANDIBULAR	\$93
D5130	IMMEDIATE DENTURE - MAXILLARY	\$93
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$93
D5211	MAX PARTIAL DENTURE - RESIN BASE	\$63
D5212	MAND PARTIAL DENTUR - RESIN BASE	\$65
D5213	MAX PART DENTUR-CAST METL W/RSN	\$80
D5214	MAND PART DENTUR- CAST METL W/RSN	\$77
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	\$63
D5226	MANDIBULAR PART DENTURE FLEX BASE	\$65
D5281	REMV UNI PART DENTUR-1 PC CAST METL	\$20
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$0
D5411	ADJUST COMPLETE DENTUR - MANDIBULAR	\$0
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$10
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$10
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	\$5
D5520	REPL MISS/BROKEN TEETH-CMPL DENTUR	\$5
D5610	REPAIR RESIN DENTURE BASE	\$10
D5620	REPAIR CAST FRAMEWORK	\$9
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	\$11
D5640	REPLACE BROKEN TEETH - PER TOOTH	\$13
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	\$8
D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	\$17
D5670	REPL ALL TEETH&ACRYLC FRMEWRK MAX	\$57
D5671	REPL ALL TEETH&ACRYLC FRMEWRK MAND	\$59
D5710	REBASE COMPLETE MAXILLARY DENTURE	\$35
D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$35
D5720	REBASE MAXILLARY PARTIAL DENTURE	\$30
D5721	REBASE MANDIBULAR PARTIAL DENTURE	\$28
D5730	RELIN CMPL MAXIL DENTURE CHAIRSIDE	\$16
D5731	RELIN CMPL MAND DENTURE CHAIRSIDE	\$16
D5740	RELIN MAXIL PART DENTURE CHAIRSIDE	\$16
D5741	RELIN MAND PART DENTURE CHAIRSIDE	\$16
D5750	RELIN CMPL MAXIL DENTURE LAB	\$27
D5751	RELIN CMPL MAND DENTURE LABORATORY	\$27
D5760	RELIN MAXIL PART DENTURE LAB	\$28

ADA	DESCRIPTION	MEMBER PAYS
D5761	RELINE MAND PART DENTURE LABORATORY	\$28
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	\$40
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	\$40
D5820	INTERIM PARTIAL DENTURE MAXILLARY	\$28
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	\$27
D5850	TISSUE CONDITIONING MAXILLARY	\$8
D5851	TISSUE CONDITIONING MANDIBULAR	\$8
D5863	OVERDENTURE - COMPLETE MAXILLARY	\$140
D5864	OVERDENTURE - COMPLETE MANDIBULAR	\$140
D5865	OVERDENTURE - PARTIAL MAXILLARY	\$140
D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$140
FIXED PROSTHODONTICS		
D5992	ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT	\$5
IMPLANT SERVICES		
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	\$1,950
D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	\$1,950
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	\$368
D6053	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR COMPLETELY EDENTULOUS	\$1,840
D6054	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS	\$1,840
D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	\$540
D6056	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	\$368
D6057	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	\$610
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	\$1,050
D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	\$915
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	\$1,050
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE META	\$946
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	\$981
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL	\$854
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	\$1,168
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	\$1,144
D6066*	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN	\$1,083
D6067*	IMPLANT SUPPORTED METAL CROWN	\$962
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	\$1,026
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	\$1,050
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	\$965
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	\$984
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE META	\$997
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	\$910
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	\$967
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	\$1,018
D6076*	IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD	\$992
D6077*	IMPLANT SUPPORTED RETAINER FOR CASE METAL FPD	\$962
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED A REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	\$55
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	\$135
D6091	REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT(MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS	\$410
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	\$79
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	\$124
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	\$810
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$55
D6100	IMPLANT REMOVAL, BY REPORT	\$600

ADA	DESCRIPTION	MEMBER PAYS
D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	\$15
D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	\$50
D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	\$350
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	\$265
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM	\$835
FIXED PROSTHODONTIC SERVICES		
D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	\$20
D6210*	PONTIC - CAST HIGH NOBLE METAL	\$67
D6211	PONTIC - CAST PREDOM BASE METAL	\$58
D6212*	PONTIC - CAST NOBLE METAL	\$64
D6214*	PONTIC TITANIUM	\$67
D6240*	PONTIC-PORCELN FUSED HI NOBLE METL	\$69
D6241	PONTIC-PORCLN FUSD PREDOM BASE METL	\$63
D6242*	PONTIC - PORCELN FUSED NOBLE METAL	\$66
D6245	PONTIC - PORCELAIN/CERAMIC	\$66
D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	\$62
D6251	PONTIC RESIN W/PREDOM BASE METAL	\$58
D6252*	PONTIC RESIN W/NOBLE METAL	\$61
D6253	PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOS NECESSARY PRIOR TO FINAL IMPRESSION	\$25
D6545	RETAINER- CASE MTL FOR RESIN FXD PROS	\$33
D6548	RET-PORC/CER FOR RESIN BONDED FIXED PROS	\$33
D6600	RETAINER INLAY-PORCELAIN/CERAMIC 2 SURFACES	\$40
D6601	RETAINER INLAY - PORCELN/CERAMIC 3/MORE SURF	\$45
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURF	\$40
D6603*	RETAINER INLAY-CAST HI NOBLE METL 3/> SURF	\$45
D6604	RETAINER INLAY-CAST PREDOM BASE METL 2 SURF	\$40
D6605	RETAINER INLAY-CAST PREDOM BASE METL 3/>SURF	\$45
D6606*	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	\$40
D6607*	RETAINER INLAY - CAST NOBLE METL 3/MORE SURF	\$45
D6608	RETAINER ONLAY - PORCELN/CERAMIC 2 SURFACES	\$45
D6609	RETAINER ONLAY - PORCELN/CERAMIC 3/MORE SURF	\$50
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURF	\$55
D6611*	RETAINER ONLAY-CAST HI NOBLE METL 3/> SURF	\$60
D6612	RETAINER ONLAY-CAST PREDOM BASE METL 2 SURF	\$50
D6613	RETAINER ONLAY-CAST PREDOM BASE METL 3/>SURF	\$55
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	\$50
D6615*	RETAINER ONLAY - CAST NOBLE METL 3/MORE SURF	\$50
D6624*	RETAINER INLAY - TITANIUM	\$45
D6634*	RETAINER ONLAY - TITANIUM	\$75
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	\$42
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	\$69
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	\$66
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	\$62
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	\$66
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	\$73
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$69
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	\$72
D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	\$72
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	\$64
D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	\$69
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	\$66
D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	\$74
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	\$69
D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	\$70
D6794*	RETAINER CROWN - TITANIUM	\$74
D6920	CONNECTOR BAR	\$70

ADA	DESCRIPTION	MEMBER PAYS
D6930	RECEMENT OR REBOND FIXED PARTIAL DENTURE	\$10
D6940	STRESS BREAKER	\$5
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	\$20
ORAL SURGERY SERVICES		
D7111	XTRCT CORONL RMNNTS DECIDUOUS TOOTH	\$0
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	\$0
D7210	SURG REMOVAL ERUPTED TOOTH	\$0
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	\$17
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	\$23
D7240	REMOVAL IMPACTED TOOTH - CMPL BONY	\$30
D7241	REMV IMP TOOTH-CMPL BNY W/SURG COMP	\$31
D7250	SURG REMOVAL RESIDUAL TOOTH ROOTS	\$14
D7251	CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL	\$5
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$10
D7270	TOOTH REIMPL&/STBL ACC DISPLCD	\$10
D7280	SURGICAL ACCESS AN UNERUPTED TOOTH	\$10
D7282	MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	\$5
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	\$30
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	\$30
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	\$15
D7288	BRUSH BIOPSY	\$15
D7290	SURGICAL REPOSITIONING OF TEETH	\$10
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	\$13
D7311	ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	\$9
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	\$14
D7321	ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	\$9
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	\$0
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT)	\$0
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER U TO 1.25 CM	\$20
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	\$30
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMET UP TO 1.25 CM	\$20
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMET GREATER THAN 1.25 CM	\$30
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$15
D7472	REMOVAL OF TORUS PALATINUS	\$30
D7473	REMOVAL OF TORUS MANDIBULARIS	\$15
D7485	SURGICAL RDUC OSSEOUS TUBEROSITY	\$25
D7510	I&D ABSCESS-INTRAORAL SOFT TISS	\$8
D7511	I & D ABSC INTRAORAL SOFT TISS COMP	\$8
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	\$8
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	\$8
D7530	REMO OF FORREIGN BODY - SKIN SUBCUTANEOUS	\$12
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	\$0
D7960	FRENULECTOMY SEPARATE PROCEDURE	\$16
D7963	FRENULOPLASTY	\$16
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	\$10
D7971	EXCISION OF PERICORONAL GINGIVA	\$10
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	\$20
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	\$0
D9120	FIXED PARTIAL DENTURE SECTIONING	\$20
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	\$0
D9211	REGIONAL BLOCK ANESTHESIA	\$0
D9212	TRIGEMINAL DIVISION BLOCK ANES	\$0

ADA	DESCRIPTION	MEMBER PAYS
D9215	LOCAL ANESTHESIA	\$0
D9220	DP SEDATION/GEN ANES-1ST 30 MIN	\$10
D9221	DP SEDAT/GEN ANES-EA ADD 15 MIN	\$5
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	\$5
D9241	IV CONSC SEDAT/ANALG -1ST 30 MIN	\$5
D9242	IV MODERATE CONSC SEDAT/ANALG-EA ADD 15 MIN	\$5
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMA AND MODERATE SEDATION	\$5
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	\$0
D9430	OV OBS - NO OTH SERVICES PERFORMED	\$0
D9440	OV-AFTER REGULARLY SCHEDULED HRS	\$25
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	\$0
D9940	OCCLUSAL GUARD BY REPORT	\$25
D9951	OCCLUSAL ADJUSTMENT - LIMITED	\$8
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$26
D9971	ODONTOPLASTY	\$0
D9972	EXTERNAL BLEACHING - PER ARCH PERFORMED IN OFFICE	\$125
ORTHODONTIC SERVICES		
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	\$1,500
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	\$1,500
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	\$1,500
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	\$150
D8999	START-UP FEE (INCLUDING EXAM, BEGINNING RECORDS, X-RAYS, TRACING, PHOTOS, AND MODELS	\$350

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

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. DENTAL PROPHYLAXIS	Limited to 1 time per 6 months
2. FLUORIDE TREATMENTS	Limited to 1 time per 6 months
3. INLAYS AND ONLAYS	Replacement of complete dentures, and fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
4. CROWNS	Retainers/Abutments - Limited to 1 time per tooth per 5 years.
5. POST AND CORES	Covered only for teeth that have had root canal therapy.
6. SCALING AND ROOT PLANING	Limited to 4 quadrants per calendar year.
7. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROTHESIS	Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implants, implant crowns, implant prosthesis previously submitted for payment under the plan is limited to 1 time per tooth per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
8. INTRAORAL BITEWING RADIOGRAPHS	Limited to 1 series of 4 films in any 6 month period
9. STAINLESS STEEL CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.
10. ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS	Limited to repairs or adjustments performed more than 6 months after the initial insertion.
11. INTRAVENOUS SEDATION OR GENERAL ANESTHESIA	Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).
12. ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's Participating Dentist. Any Covered Person who elects specialist care without prior referral by his or her Participating Dentist and approval by us is responsible for all charges incurred. <ul style="list-style-type: none"> • In order for specialty services to be Covered by this plan, the following referral process must be followed: • A Covered Person's Participating Dentist must coordinate all Dental Services. • When the care of a Network Specialist Dentist is required, the Covered Person's Participating Dentist must contact us and request authorization. • If the Participating Dentist request for specialist referral is denied, the Participating Dentist and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the Participating Dentist may be asked to perform the service. • Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services. • Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.
13. PERIODONTAL MAINTENANCE PROCEDURES	Limited to once every 6 months, following active therapy, exclusive of gross debridement
14. REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (MINOR RESTORATIVE SERVICES)	Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 years from initial or supplemental placement
15. CROWNS, FIXED BRIDGES, AND IMPLANTS	The maximum benefit within a 12-month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12-month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Charges.
16. ADJUNCTIVE	Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesion, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
17. INTRAORAL	Complete Series (including bitewings) - Limited to 1 time in any 2-year period
18. TEMPORARY CROWNS	Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.

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. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
3. Any Dental Procedure not directly associated with dental disease.
4. Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.

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:

5.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
6.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
7.	Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
8.	Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
9.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
10.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
11.	Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Service dental conditions arising prior to the date individual Coverage under the Policy terminates.
12.	Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
13.	Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
14.	Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Primary Care Dentist, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
15.	Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
16.	Removable Prosthetics/Fixed Prosthetics/Crowns, Inlays and Onlays (Major Restorative Services) - The plan provides for the use of noble metals for inlay onlays, crowns and fixed bridges. When high noble metal is used, the Covered Person must pay: (a) the Copayment for the inlay, onlay, crown or fixed bridge; and (b) an added charge equal to the actual laboratory cost of the high noble metal.
17.	Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
18.	Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by a Participating Dentist; or (b) treatment by a speci without referral from a Participating Dentist and our approval.
19.	Any Dental Procedure not performed in a dental setting. This will not apply to Covered Emergency Dental Services.
20.	Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
21.	Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare
22.	Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.
23.	<p>Orthodontic Exclusions & Limitations</p> <p>If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatm the Covered Person will be responsible for all costs associated with any orthodontic treatment. Orthodontic services Copayments are valid for authorized services rendered.</p> <p>If you terminate Coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.</p> <p>1. The following are not covered orthodontic benefits:</p> <ul style="list-style-type: none">a) Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Personb) Treatment in progress prior to the effective date of this coveragec) Extractions required for orthodontic purposesd) Surgical orthodontics or jaw repositioninge) Myofunctional therapyf) Cleft palateg) Micrognathiah) Macroglossiai) Hormonal imbalancesj) Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of treatment accidentk) Palatal expansion appliancesl) Services performed by outside laboratories <p>2. If a treatment plan is for less than 24 months, then a prorated portion of the full copayment shall apply.</p> <p>3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remainin cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.</p> <p>4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment progr the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.</p> <p>5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this Comprehensive Orthodontic Treatment. If comprehensive treatment is necessary, and is completed within a 24 month period, the Copayments listed will apply. If necessary and active treatment extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider m charge usual and customary fees for active treatment extending beyond the 24 month benefit period.</p>