UnitedHealthcare® dental plan

In Network Only National Options PPO 10 Network/covered dental services

PI096 /MAC

	NON-ORTHODONTICS NETWORK	ORTHODONTICS NETWORK OR NON-NETWORK
Individual Annual Deductible	$0	$0
Family Annual Deductible	$0	
Annual Maximum Benefit *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$5000 per person per Plan Year	$2000 per person per Lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No	
Annual Deductible Applies to Orthodontic Services	No	
Waiting Period	No waiting period	
Orthodontic Eligibility Requirement	Adult & Child	
Orthodontic Services (Diagnose or correct misaligment of teeth or bite)	50%	50%

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
D0171	RE-EVALUATION – POST-OPERATIVE OFFICE VISIT	$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0190	SCREENING OF A PATIENT	$0
D0191	ASSESMENT OF A PATIENT	$0
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$0
D0230	INTRAORL PERIAPICAL EA ADD 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	POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL SURVEY RADIOGRAPHIC IMAGE	$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$0
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY	$0
D0351	3D PHOTOGRAPHIC IMAGE	$0
D0364	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$10
D0365	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$10
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$15
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$15
D0368	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$20
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	$5
D0414	LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0
D0415	COLLECT MICROORAGNISMS CULT & SENS	$0
D0416	VIRAL CULTURE	$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	$0
D0418	ANALYSIS OF SALIVA SAMPLE	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$0

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ADA	DESCRIPTION	MEMBER PAYS*
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	$0
D1352	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$0
D1353	SEALANT REPAIR – PER TOOTH	$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
D1550	RECEMENT OR RE-BOND SPACE MAINTAINER	$0
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$0
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED – UNILATERAL	$0
RESTORATIVE SERVICES		
D2140	AMALGAM-ONE SURFACE PRIMARY/PERM	$5
D2150	AMALGAM-TWO SURFACES PRIMARY/PERM	$5
D2160	AMALGAM-3 SURFACES PRIMARY/PERM	$10
D2161	AMALGAM-FOUR/MORE SURF PRIM/PERM	$10
D2330	RESIN COMPOS - ONE SURFACE ANTERIOR	$5
D2331	RESIN COMPOS - 2 SURFACES ANTERIOR	$5
D2332	RESIN COMPOS - 3 SURFACES ANTERIOR	$10
D2335	RSN COMPOS-4/> SURF/W/INCISAL ANG	$10
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
D2420	GOLD FOIL - TWO SURFACES	$120
D2430	GOLD FOIL - THREE SURFACES	$185
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

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ADA	DESCRIPTION	MEMBER PAYS*
D2710	CROWN RESINBASED COMPOSITE INDIRECT	$20
D2712	CROWN 3/4 RESNBASED COMPOS INDIRECT	$20
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	$40
D2721	CROWN - RESIN W/PREDOM BASE METAL	$30
D2722	CROWN - RESIN WITH NOBLE METAL	$30
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$100
D2750	CROWN - PORCELN FUSED HI NOBLE METL	$100
D2751	CROWN-PORCELN FUSD PREDOM BASE METL	$90
D2752	CROWN - PORCELAIN FUSED NOBLE METAL	$100
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	$95
D2781	CROWN - 3/4 CAST PREDOM BASE METL	$90
D2782	CROWN - 3/4 CAST NOBLE METAL	$95
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$95
D2790	CROWN - FULL CAST HIGH NOBLE METAL	$100
D2791	CROWN - FULL CAST PREDOM BASE METL	$90
D2792	CROWN - FULL CAST NOBLE METAL	$100
D2794	CROWN TITANIUM	$100
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$5
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFAB POST & CORE	$5
D2920	RECEMENT OR RE-BOND CROWN	$5
D2921	REATTACHMENT OF TOOTH FRAGMENT	$5
D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	$10
D2930	PRFABR STAINLESS STEEL CROWN-PRIM	$10
D2931	PRFABR STAINLESS STEEL CROWN-PERM	$10
D2932	PREFABRICATED RESIN CROWN	$10
D2933	PRFABR STNLSS STEEL CROWN RSN WNDOW	$10
D2934	PREFAB ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	$10
D2940	SEDATIVE FILLING	$5
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$5
D2950	CORE BUILDUP INCLUDING ANY PINS	$5
D2951	PIN RETN - PER TOOTH ADDITION REST	$5
D2952	POST & CORE ADD CROWN INDIRECT FAB	$25
D2953	EA ADD INDIRECT FAB POST SAME TOOTH	$5
D2954	PREFABR POST&CORE ADDITION CROWN	$10
D2955	POST REMOVAL	$20
D2957	EA ADD PREFABR POST - SAME TOOTH	$5
D2960	LABIAL VENEER (LAMINATE) - CHAIRSIDE	$20
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$40
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$40
D2971	ADD PROC NEW CROWN XST PART DENTURE	$10
D2975	COPING	$70
D2980	CROWN REPAIR	$15
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$10
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	$5
D3222	PARTIAL PULPOTOMY	$0
D3230	PULPAL THERAPY - ANT PRIMARY TOOTH	$0
D3240	PULPAL THERAPY - POST PRIMARY TOOTH	$0
D3310	ANTERIOR	$15
D3320	BICUSPID	$20
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	$15
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$20
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$35

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D3351	APEXIFICAT/RECALCIFICAT - INIT VST	$5
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	$15
D3421	APICOECTOMY SURG-BICUSPID	$20
D3425	APICOECTOMY SURG - MOLAR	$30
D3426	APICOECTOMY SURGERY	$10
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$13
D3430	RETROGRADE FILLING - PER ROOT	$10
D3450	ROOT AMPUTATION - PER ROOT	$12
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$1,950
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$5
D3920	HEMISECTION NOT INCL RC THERAPY	$5
D3950	CANAL PREP&FIT PREFORMED DOWEL/POST	$5
PERIODONTIC SERVICES		
D4210	GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	$10
D4211	GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	$5
D4212	GINGIVECT/PLSTY WITH REST PROC/TOOTH	$0
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$10
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$5
D4245	APICALLY POSITIONED FLAP	$10
D4249	CLIN CROWN LEN - HARD TISSUE	$10
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$30
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$20
D4263	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	$15
D4263	BONE REPLCMT GRAFT - 1 SITE QUAD	$15
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$10
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	$10
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$10
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	$5
D4341	PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	$5
D4342	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	$5
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$0
D4355	FULL MOUTH DEBRID COMP EVAL&DX	$5
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE 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	$140
D5120	COMPLETE DENTURE - MANDIBULAR	$140
D5130	IMMEDIATE DENTURE - MAXILLARY	$140
D5140	IMMEDIATE DENTURE - MANDIBULAR	$140
D5211	MAX PARTIAL DENTURE - RESIN BASE	$40
D5212	MAND PARTIAL DENTUR - RESIN BASE	$40
D5213	MAX PART DENTUR-CAST METL W/RSN	$140
D5214	MAND PART DENTUR- CAST METL W/RSN	$140
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$30
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$30

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D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$30
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$30
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$40
D5226	MANDIBULAR PART DENTURE FLEX BASE	$40
D5281	REMV UNI PART DENTUR-1 PC CAST METL	$20
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$5
D5411	ADJUST COMPLETE DENTUR - MANDIBULAR	$5
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$5
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$5
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	$10
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$10
D5520	REPL MISS/BROKEN TEETH-CMPL DENTUR	$5
D5611	REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	$10
D5612	REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	$10
D5621	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$25
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$25
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$25
D5640	REPLACE BROKEN TEETH - PER TOOTH	$10
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$10
D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$20
D5670	REPL ALL TEETH&ACRYLC FRMEWRK MAX	$45
D5671	REPL ALL TEETH&ACRYLC FRMEWRK MAND	$45
D5710	REBASE COMPLETE MAXILLARY DENTURE	$40
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$40
D5720	REBASE MAXILLARY PARTIAL DENTURE	$30
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$30
D5730	RELINE CMPL MAXIL DENTURE CHAIRSIDE	$25
D5731	RELINE CMPL MAND DENTURE CHAIRSIDE	$25
D5740	RELINE MAXIL PART DENTURE CHAIRSIDE	$20
D5741	RELINE MAND PART DENTURE CHAIRSIDE	$20
D5750	RELINE CMPL MAXIL DENTURE LAB	$30
D5751	RELINE CMPL MAND DENTRUE LABORATORY	$30
D5760	RELINE MAXIL PART DENTURE LAB	$30
D5761	RELINE MAND PART DENTURE LABORATORY	$30
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$40
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$40
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$30
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$30
D5850	TISSUE CONDITIONING MAXILLARY	$5
D5851	TISSUE CONDITIONING MANDIBULAR	$5
D5863	OVERDENTURE - COMPLETE MAXILLARY	$140
D5864	OVERDENTURE - COMPLETE MANDIBULAR	$140
D5865	OVERDENTURE - PARTIAL MAXILLARY	$140
D5866	OVERDENTURE - PARTIAL MANDIBULAR	$140
IMPLANT SERVICES		
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,950
D6011	SECOND STAGE IMPLANT SURGERY	$1,950
D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	$1,950
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	$368
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 METAL)	$946
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$981

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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 METAL)	$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 AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$55
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	$15
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
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$20
D6100	IMPLANT REMOVAL, BY REPORT	$600
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
D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$1,840
D6111	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$1,840
D6112	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$1,840
D6113	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$1,840
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$40
D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$40
D6190		$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	$80
D6211	PONTIC - CAST PREDOM BASE METAL	$75
D6212	PONTIC - CAST NOBLE METAL	$80
D6214	PONTIC TITANIUM	$80
D6240	PONTIC-PORCELN FUSED HI NOBLE METL	$80
D6241	PONTIC - PORCELN FUSED PREDOM BASE METL	$75
D6242	PONTIC - PORCELN FUSED NOBLE METAL	$80
D6245	PONTIC - PORCELAIN/CERAMIC	$95
D6250	PONTIC - RESIN W/HIGH NOBLE METAL	$25

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ADA	DESCRIPTION	MEMBER PAYS*
D6251	PONTIC RESIN W/PREDOM BASE METAL	$15
D6252	PONTIC RESIN W/NOBLE METAL	$15
D6253	PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$25
D6545	RETAINER- CASE MTL FOR RESIN FXD PROS	$10
D6548	RET-PORC/CER FOR RESIN BONDED FIXED PROS	$10
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	$10
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	$20
D6720	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$40
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$30
D6722	RETAINER CROWN - RESIN WITH NOBLE METAL	$30
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$100
D6750	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$100
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$90
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$100
D6780	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$95
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$90
D6782	RETAINER CROWN - 3/4 CAST NOBLE METAL	$95
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$95
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$100
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$90
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	$100
D6794	RETAINER CROWN - TITANIUM	$100
D6920	CONNECTOR BAR	$70
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$5
D6940	STRESS BREAKER	$5
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$20
ORAL SURGERY SERVICES		
D7111	XTRCT CORONL RMNNTS DECIDUOUS TOOTH	$5
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$5
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$5
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$10
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$20
D7240	REMOVAL IMPACTED TOOTH - CMPL BONY	$15
D7241	REMV IMP TOOTH-CMPL BNY W/SURG COMP	$25
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$5
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	$5
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$10
D7270	TOOTH REIMPL&/STBL ACC DISPLCD	$10
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$10
D7280	SURGICAL ACCESS AN UNERUPTED TOOTH	$10

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ADA	DESCRIPTION	MEMBER PAYS*
D7282	MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	$5
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$5
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$5
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$5
D7288	BRUSH BIOPSY	$5
D7290	SURGICAL REPOSITIONING OF TEETH	$10
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$5
D7311	ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	$5
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$10
D7321	ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	$5
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$20
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$30
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP 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 DIAMETER UP TO 1.25 CM	$20
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER 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	REDUCTION OF OSSEOUS TUBEROSITY	$25
D7485	SURGICAL RDUC OSSEOUS TUBEROSITY	$25
D7510	I&D ABSCESS-INTRAORAL SOFT TISS	$5
D7511	I & D ABSC INTRAORAL SOFT TISS COMP	$5
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$10
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$10
D7530	REMO OF FORREIGN BODY - SKIN SUBCUTANEOUS	$5
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$0
D7960	FRENULECTOMY SEPARATE PROCEDURE	$5
D7963	FRENULOPLASTY	$5
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	$5
D9120	FIXED PARTIAL DENTURE SECTIONING	$15
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
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	$0
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	$10
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$5
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$5
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$10
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANELGESIA - EACH 15 MINUTES INCREMENT	$5
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL 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	$5
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9940	OCCLUSAL GUARD BY REPORT	$15
D9943	OCCLUSAL GUARD ADJUSTMENT	$5
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$5
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$5
D9971	ODONTOPLASTY	$0
D9972	EXTERNAL BLEACHING - PER ARCH PERFORMED IN OFFICE	$125

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ADA	DESCRIPTION	MEMBER PAYS*
D9995	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW	$0
D9996	BROKEN APPOINTMENT	$0
FixedProsthedontics		
D5900	-	$5

*The network enrollee copay will be lesser of the copay shown above and the discounted fee negotiated with the provider.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.
UnitedHealthcare Dental® In Network Only (INO) Plan is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppage, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United HealthCare Services, Inc.

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UnitedHealthcare/dental exclusions and limitations

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

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

GENERAL LIMITATIONS

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

GENERAL EXCLUSIONS

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. Placement of dental implants, implant-supported abutments and prostheses.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns 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.
14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

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GENERAL EXCLUSIONS

18. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
20. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan Coverage unless the patient has been Covered under the Policy for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 period, the plan is responsible only for the procedures associated with the addition.
21. Replacement of missing natural teeth lost prior to the onset of plan Coverage until the patient has been Covered under the Policy for 12 continuous months.
22. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
25. 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.
26. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
27. 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.
28. Foreign Services are not Covered unless required as an Emergency.
29. 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.
30. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

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