UnitedHealthcare Dental®

DHMO Malibu 130/covered dental services

dental plan
D250H/D251H

ADA	DESCRIPTION	MEMBER'S COPAYMENT
DIAGNOSTIC SERVICES		
D0120	PERIODIC ORAL EVALUATION EST PT	$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$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
D0210	INTRAORAL-COMPLETE SERIES	$0
D0220	INTRAORAL PERIAPICAL FIRST FILM	$0
D0230	INTRAORL PERIAPICAL EA ADD FILM	$0
D0240	INTRAORAL - OCCLUSAL FILM	$0
D0250	EXTRAORAL - FIRST FILM	$0
D0260	EXTRAORAL - EACH ADDITIONAL FILM	$0
D0270	BITEWING - SINGLE FILM	$0
D0272	BITEWINGS - TWO FILMS	$0
D0273	BITEWINGS - THREE FILMS	$0
D0274	BITEWINGS - FOUR FILMS	$0
D0277	VERTICAL BITEWINGS - 7 TO 8 FILMS	$0
D0330	PANORAMIC FILM	$0
D0415	COLLECT MICROORAGNISMS CULT & SENS	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$20
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
D0999	OFFICE VISIT FEE - PER VISIT	$0
PREVENTIVE SERVICES		
D1110	PROPHYLAXIS - ADULT [1]	$0
--------	PROPHYLAXIS - ADULT [1] Add. Prophy within 6 months	$25
D1120	PROPHYLAXIS - CHILD [1]	$0
--------	PROPHYLAXIS - CHILD [1] Add. Prophy within 6 months	$25
D1203	TOP FLUORIDE - CHILD	$0
D1204	TOP FLUORIDE - ADULT	$0
D1206	TOP FLUORIDE; TX APPL MOD-HI RISK	$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	$8
D1510	SPACE MAINTAINER - FIXED-UNILATERAL	$25
D1515	SPACE MAINTAINER - FIXED-BILATERAL	$25
D1520	SPACE MAINTAINER - REMOVABLE-UNI	$40
D1525	SPACE MAINTAINER - REMOVABLE-BIL	$40
D1550	RECEMENTATION OF SPACE MAINTAINER	$15
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$15
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

ADA	DESCRIPTION	MEMBER'S COPAYMENT
RESTORATIVE SERVICES*		
D2335	RSN COMPOS-4/> SURF/W/INCISAL ANG	$0
D2390	RESIN COMPOS CROWN ANTERIOR	$40
D2391	RESIN COMPOS - 1 SURFACE POSTERIOR	$40
D2392	RESIN COMPOS - 2 SURFACES POSTERIOR	$45
D2393	RESIN COMPOS - 3 SURFACES POSTERIOR	$75
D2394	RESIN COMPOS - 4/MORE SURFACES POST	$75
D2510	INLAY - METALLIC - ONE SURFACE	$175
D2520	INLAY - METALLIC - TWO SURFACES	$175
D2530	INLAY - METALLIC - 3/MORE SURFACES	$175
D2542	ONLAY - METALLIC - TWO SURFACES	$225
D2543	ONLAY METALLIC THREE SURFACES	$225
D2544	ONLAY METALLIC FOUR OR MORE SURF	$225
D2610	INLAY - PORCELN/CERAMIC - 1 SURFACE	$250
D2620	INLAY - PORCELN/CERAMIC - 2 SURF	$250
D2630	INLAY - PORCELN/CERAM - 3/MORE SURF	$250
D2642	ONLAY - PORCELN/CERAMIC - 2 SURF	$250
D2643	ONLAY - PORCELN/CERAMIC - 3 SURF	$250
D2644	ONLAY - PORCELN/CERAM - 4/MORE SURF	$250
D2650	INLAY-RSN COMPOS COMPOS/RSN-1 SURF	$250
D2651	INLAY-RSN COMPOS COMPOS/RSN-2 SURF	$250
D2652	INLAY-RSN COMPOS COMPOS/RSN-3/>SURF	$250
D2662	ONLAY-RSN COMPOS COMPOS/RSN-2 SURF	$250
D2663	ONLAY-RSN COMPOS COMPOS/RSN-3 SURF	$250
D2664	ONLAY-RSN COMPOS COMPOS/RSN-4/>	$250
D2710	CROWN RESINBASED COMPOSITE INDIRECT	$150
D2712	CROWN 3/4 RESNBASED COMPOS INDIRECT	$150
D2720	CROWN - RESIN WITH HIGH NOBLE METAL*	$250
D2721	CROWN - RESIN W/PREDOM BASE METAL	$250
D2722	CROWN - RESIN WITH NOBLE METAL*	$250
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$300
D2750	CROWN - PORCELN FUSED HI NOBLE METL*	$250
D2751	CROWN-PORCELN FUSD PREDOM BASE METL	$250
D2752	CROWN - PORCELAIN FUSED NOBLE METAL *	$250
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL*	$250
D2781	CROWN - 3/4 CAST PREDOM BASE METL	$250
D2782	CROWN - 3/4 CAST NOBLE METAL *	$250
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$250
D2790	CROWN - FULL CAST HIGH NOBLE METAL*	$250
D2791	CROWN - FULL CAST PREDOM BASE METL	$250
D2792	CROWN - FULL CAST NOBLE METAL *	$250
D2794	CROWN TITANIUM *	$250
D2910	RECEMENT INLAY ONLAY/PART COV REST	$0
D2915	RECEMENT CAST/PREFAB POST & CORE	$0
D2920	RECEMENT CROWN	$0
D2930	PRFABR STAINLESS STEEL CROWN-PRIM	$25
D2931	PRFABR STAINLESS STEEL CROWN-PERM	$25
D2932	PREFABRICATED RESIN CROWN	$40
D2933	PRFABR STNLSS STEEL CROWN RSN WNDOW	$40
D2940	SEDATIVE FILLING	$0
D2950	CORE BUILDUP INCLUDING ANY PINS	$50
D2951	PIN RETN - PER TOOTH ADDITION REST	$10
D2952	POST & CORE ADD CROWN INDIRECT FAB	$40
D2953	EA ADD INDIRECT FAB POST SAME TOOTH	$40

ADA	DESCRIPTION	MEMBER'S COPAYMENT
D2954	PREFABR POST&CORE ADDITION CROWN	$25
D2955	POST REMOVAL	$10
D2957	EA ADD PREFABR POST - SAME TOOTH	$30
D2970	TEMPORARY CROWN	$0
D2971	ADD PROC NEW CROWN XST PART DENTURE	$50
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	$30
D3230	PULPAL THERAPY - ANT PRIMARY TOOTH	$40
D3240	PULPAL THERAPY - POST PRIMARY TOOTH	$40
D3310	ANTERIOR	$95
D3320	BICUSPID	$175
D3330	MOLAR	$305
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$85
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$85
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$85
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$115
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$175
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$300
D3351	APEXIFICAT/RECALCIFICAT - INIT VST	$70
D3352	APEXIFICAT/RECALCIFICAT-INTERIM	$70
D3353	APEXIFICAT/RECALCIFICAT-FINAL VISIT	$70
D3410	APICOECT/PERIRADICULAR SURG - ANT	$95
D3421	APICOECT/PERIRADICULR SURG-BICUSPID	$95
D3425	APICOECT/PERIRADICULAR SURG - MOLAR	$95
D3426	APICOECTOMY/PERIRADICULAR SURGERY	$55
D3430	RETROGRADE FILLING - PER ROOT	$55
D3450	ROOT AMPUTATION - PER ROOT	$95
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$15
D3920	HEMISECTION NOT INCL RC THERAPY	$90
D3950	CANAL PREP&FIT PREFORMED DOWEL/POST	$15
PERIODONTIC SERVICES		
D4210	GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	$115
D4211	GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	$80
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$150
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$165
D4245	APICALLY POSITIONED FLAP	$155
D4249	CLIN CROWN LEN - HARD TISSUE	$145
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$325
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$225
D4263	BONE REPLCMT GRAFT - 1 SITE QUAD	$175
D4264	BN REPLCMT GRAFT - EA ADD SITE QUAD	$90
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$225
D4271	FREE SOFT TISSUE GRAFT PROCEDURE	$225
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	$85
D4341	PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	$45
D4342	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	$45
D4355	FULL MOUTH DEBRID COMP EVAL&DX	$50
D4381	LOC DEL ANTIMICROBIAL AGT TOOTH BR	$55
D4910	PERIODONTAL MAINTENANCE	$30
D4920	UNSCHEDULED DRESSING CHANGE	$0
REMOVEABLE PROSTHODONTICS SERVICES*		
D5110	COMPLETE DENTURE - MAXILLARY	$275
D5120	COMPLETE DENTURE - MANDIBULAR	$275
D5130	IMMEDIATE DENTURE - MAXILLARY	$315
D5140	IMMEDIATE DENTURE - MANDIBULAR	$315

ADA	DESCRIPTION	MEMBER'S COPAYMENT
REMOVEABLE PROSTHODONTICS SERVICES*		
D5211	MAX PARTIAL DENTURE - RESIN BASE	$250
D5212	MAND PARTIAL DENTUR - RESIN BASE	$250
D5213	MAX PART DENTUR-CAST METL W/RSN	$325
D5214	MAND PART DENTUR- CAST METL W/RSN	$325
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$325
D5226	MANDIBULAR PART DENTURE FLEX BASE	$325
D5281	REMV UNI PART DENTUR-1 PC CAST METL	$275
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$10
D5411	ADJUST COMPLETE DENTUR - MANDIBULAR	$10
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$10
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$10
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	$30
D5520	REPL MISS/BROKEN TEETH-CMPL DENTUR	$30
D5610	REPAIR RESIN DENTURE BASE	$30
D5620	REPAIR CAST FRAMEWORK	$30
D5630	REPAIR OR REPLACE BROKEN CLASP	$30
D5640	REPLACE BROKEN TEETH - PER TOOTH	$30
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$30
D5660	ADD CLASP EXISTING PARTIAL DENTURE	$30
D5670	REPL ALL TEETH&ACRYLC FRMEWRK MAX	$150
D5671	REPL ALL TEETH&ACRYLC FRMEWRK MAND	$150
D5710	REBASE COMPLETE MAXILLARY DENTURE	$65
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$65
D5720	REBASE MAXILLARY PARTIAL DENTURE	$65
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$65
D5730	RELINE CMPL MAXIL DENTURE CHAIRSIDE	$55
D5731	RELINE CMPL MAND DENTURE CHAIRSIDE	$55
D5740	RELINE MAXIL PART DENTURE CHAIRSIDE	$55
D5741	RELINE MAND PART DENTURE CHAIRSIDE	$55
D5750	RELINE CMPL MAXIL DENTURE LAB	$75
D5751	RELINE CMPL MAND DENTRUE LABORATORY	$75
D5760	RELINE MAXIL PART DENTURE LAB	$75
D5761	RELINE MAND PART DENTURE LABORATORY	$75
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$115
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$115
D5850	TISSUE CONDITIONING MAXILLARY	$20
D5851	TISSUE CONDITIONING MANDIBULAR	$20
FIXED PROSTHODONTICS SERVICES*		
D6210	PONTIC - CAST HIGH NOBLE METAL*	$250
D6211	PONTIC - CAST PREDOM BASE METAL	$250
D6212	PONTIC - CAST NOBLE METAL *	$250
D6214	PONTIC TITANIUM *	$250
D6240	PONTIC-PORCELN FUSED HI NOBLE METL *	$250
D6241	PONTIC-PORCLN FUSD PREDOM BASE METL	$250
D6242	PONTIC - PORCELN FUSED NOBLE METAL *	$250
D6245	PONTIC - PORCELAIN/CERAMIC	$300
D6250	PONTIC - RESIN W/HIGH NOBLE METAL *	$250
D6251	PONTIC RESIN W/PREDOM BASE METAL	$250
D6252	PONTIC RESIN W/NOBLE METAL *	$250
D6600	INLAY-PORCELAIN/CERAMIC 2 SURFACES	$270
D6601	INLAY - PORCELN/CERAMIC 3/MORE SURF	$270
D6602	INLAY - CAST HI NOBLE METAL 2 SURF	$175
D6603	INLAY-CAST HI NOBLE METL 3/> SURF	$175
D6604	INLAY-CAST PREDOM BASE METL 2 SURF	$175
D6605	INLAY-CAST PREDOM BASE METL 3/>SURF	$175
D6606	INLAY - CAST NOBLE METAL 2 SURFACES	$175
D6607	INLAY - CAST NOBLE METL 3/MORE SURF	$175

ADA	DESCRIPTION	MEMBER'S COPAYMENT
FIXED PROSTHODONTICS SERVICES*		
D6608	ONLAY - PORCELN/CERAMIC 2 SURFACES	$280
D6609	ONLAY - PORCELN/CERAMIC 3/MORE SURF	$280
D6610	ONLAY - CAST HI NOBLE METAL 2 SURF	$175
D6611	ONLAY-CAST HI NOBLE METL 3/> SURF	$175
D6612	ONLAY-CAST PREDOM BASE METL 2 SURF	$175
D6613	ONLAY-CAST PREDOM BASE METL 3/>SURF	$175
D6614	ONLAY - CAST NOBLE METAL 2 SURFACES	$175
D6615	ONLAY - CAST NOBLE METL 3/MORE SURF	$175
D6624	INLAY TITANIUM	$250
D6634	ONLAY TITANIUM	$250
D6720	CROWN - RESIN WITH HIGH NOBLE METAL *	$250
D6721	CROWN RESIN PREDOM BASE METL-DENTUR	$250
D6722	CROWN - RESIN WITH NOBLE METAL *	$250
D6740	CROWN - PORCELAIN/CERAMIC	$300
D6750	CRWN PORCLN FUSD HI NOBL MTL-DENTUR *	$250
D6751	CROWN-PORCELN FUSD PREDOM BASE METL	$250
D6752	CROWN - PORCELAIN FUSED NOBLE METAL *	$250
D6780	CROWN - 3/4 CAST HIGH NOBLE METAL *	$250
D6781	CROWN-3/4 CAST PREDOM BASED METAL	$250
D6782	CROWN 3/4 CAST NOBLE METAL-DENTURE *	$250
D6783	CROWN 3/4 PORCELAIN/CERAMIC-DENTURE	$300
D6790	CROWN FULL CAST HI NOBL METL-DENTUR *	$250
D6791	CROWN FULL CAST BASE METAL-DENTURE	$250
D6792	CROWN FULL CAST NOBLE METAL-DENTURE *	$250
D6794	CROWN TITANIUM *	$250
D6930	RECEMENT FIXED PARTIAL DENTURE	$0
D6940	STRESS BREAKER	$125
D6970	POST&CORE ADD FIX PART DENTURE RET	$50
D6972	PRFAB POST&COR ADD PART DENTUR RETN	$30
D6973	CORE BUILD UP RETAIN INCL ANY PINS	$10
D6976	EA ADD INDIRECT FAB POST SAME TOOTH	$50
D6977	EACH ADD PRFAB POST SAME TOOTH	$50
ORAL SURGERY SERVICES		
D7111	XTRCT CORONL RMNNTS DECIDUOUS TOOTH	$8
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$8
D7210	SURG REMOVAL ERUPTED TOOTH	$30
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$55
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$85
D7240	REMOVAL IMPACTED TOOTH - CMPL BONY	$125
D7241	REMV IMP TOOTH-CMPL BNY W/SURG COMP	$150
D7250	SURG REMOVAL RESIDUAL TOOTH ROOTS	$40
D7270	TOOTH REIMPL&/STBL ACC DISPLCD	$50
D7280	SURGICAL ACCESS AN UNERUPTED TOOTH	$85
D7282	MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	$90
D7285	BIOPSY OF ORAL TISSUE HARD	$150
D7286	BIOPSY OF ORAL TISSUE SOFT	$60
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$40
D7311	ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	$15
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$60
D7321	ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	$25
D7471	REMOVAL OF LATERAL EXOSTOSIS	$85
D7472	REMOVAL OF TORUS PALATINUS	$65

ADA	DESCRIPTION	MEMBER'S COPAYMENT
ORAL SURGERY SERVICES		
D7473	REMOVAL OF TORUS MANDIBULARIS	$65
D7485	SURGICAL RDUC OSSEOUS TUBEROSITY	$65
D7510	I&D ABSCESS-INTRAORAL SOFT TISS	$35
D7511	I & D ABSC INTRAORAL SOFT TISS COMP	$35
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$25
D7960	FRENULECTOMY SEPARATE PROCEDURE	$45
D7963	FRENULOPLASTY	$45
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$55
D7971	EXCISION OF PERICORONAL GINGIVA	$40
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$100
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$10
D9211	REGIONAL BLOCK ANESTHESIA	$0
D9212	TRIGEMINAL DIVISION BLOCK ANES	$0
D9215	LOCAL ANESTHESIA	$0
D9220	DP SEDATION/GEN ANES-1ST 30 MIN	$155
D9221	DP SEDAT/GEN ANES-EA ADD 15 MIN	$75
D9241	IV CONSC SEDAT/ANALG -1ST 30 MIN	$155
D9242	IV CONSC SEDAT/ANALG-EA ADD 15 MIN	$70
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$0
D9430	OV OBS - NO OTH SERVICES PERFORMED	$5
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$35
D9450	CASE PRSATION DTL&EXT TX PLANNING	$0
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9940	OCCLUSAL GUARD BY REPORT	$85
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$30
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$90
D9972	EXTERNAL BLEACHING - PER ARCH	$125
D9999	BROKEN APPOINTMENT	$20
ORTHODONTIC SERVICES		
D8070	Comprehensive orthodontic treatment transitional dentition	$1,895
D8080	Comprehensive orthodontic treatment adolescent dentition	$1,895
D8090	Comprehensive orthodontic treatment adult dentition	$1,895
D8680	Orthodontic retention (removal of appliances, construction, and placement of retainers)	$300
D8999	Start-up fee (including exam, beginning records, x-rays, tracing, photos, and models	$250
D8999	Post Treatment Records	$150

1. Additional Prophy within 6 months wil be based upon the necessity recommended by the provider.
2. Specialty family calendar year maximum does not apply to the listed plans. Copays listed are also applicable in the specialist office.

* Lab upgrades including specialized services for dentures, and charges for the cost of precious metals (noble, high noble, titanium) are the Members responsibility. Fees to the Member for upgrades will be limited to the additional laboratory fee charged to the dentist by the dental laboratory.

UnitedHealthcare Dental/HMO 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. PROPHYLAXIS - Routine cleaning of teeth, including scaling and polishing procedures to remove coronal plaque, calculus and stains, is an allowable preventive benefit once every 6 months.
2. FULL MOUTH RADIOGRAPHS (X-rays) are limited to once in any 2-year period. Bitewing X-rays are limited to no more than 1 series of 4 films in any 6-month period.
3. FLUORIDE TREATMENTS are limited to only once per calendar year.
4. PERIODONTAL SCALING AND ROOT PLANING - Both procedures are allowable only when the need can be demonstrated radiographically and/or by pocket charting. There is a maximum of 4 quadrants per calendar year.
5. PERIODONTAL MAINTENANCE PROCEDURES are a benefit following active therapy (previous to periodontal treatment) once every 6 months at the Specialist's office when referred by your Assigned Dental Provider Group, or provided at your Assigned Dental Provider Group
6. PROSTHETICS

A. REMOVABLE PROSTHETICS

1. Temporary or Transitional Dentures - Temporary or transitional full dentures are not a covered benefit. However, with some benefit packages, an exception is made for an anterior stayplate when this interim appliance either:
   a) Replaces natural, permanent, anterior teeth, during the healing period immediately after extraction or traumatic tooth loss; or
   b) Replaces extracted or lost natural, permanent, anterior teeth for Members under 16 years of age.
2. Laboratory Upgrades including specialized services for Dentures are not covered. Fees to the Member for upgrades will be limited to the additional laboratory fee charged to the dentist by the dental laboratory for the upgrade. Upgrades include, but are not limited to:
   a) Precious metal for removable appliance framework or a metal base for a full denture;
   b) Personalization and characterization;
   c) Specialized materials;
   d) Specialized services or techniques involving precision attachments or stress breakers.
3. Dentures, Replacement, Repairs and Relines
   a) For existing full or partial dentures, the addition of new denture teeth is covered if a natural tooth or a denture tooth is lost. Replacement of an existing full or partial denture is covered only if the existing denture is at least five years old, has been determined unserviceable by your Assigned Dental Provider Group and cannot be made serviceable. However, replacement of an unserviceable full or partial denture that is less than five years old is covered if the denture was provided by a DBP-CA Participating Provider and is determined by DBP-CA Dental to be unserviceable because the diagnosis, treatment, fabrication, or placement rendered by that dentist did not meet applicable standards of dental care.
   b) If an existing permanent denture needs to be repaired and/or relined to be made serviceable, then repairs and/or relines are also a benefit. The addition of denture teeth, repairs and relines of secondary ("back-up," "spare" or "temporary") dentures are not covered benefits.
   c) Denture adjustments - Adjustments for new dentures are included in the Copayment for the denture for 6 months following delivery. For existing dentures, or new dentures after the initial 6 months, the Member is responsible for the listed Copayment for a denture adjustment. Adjustments of secondary ("back-up" or "spare") dentures are not a covered benefit.

B. FIXED PROSTHETICS:

1. A fixed bridge is a benefit to replace missing natural teeth, unless based on professionally recognized standards:
   a) The clinical condition of the teeth that would support the bridge is unfavorable.
   b) There are inadequate teeth available to support the bridge
   c) The same dental arch has a serviceable existing partial denture to which additional denture teeth may be added to replace the missing natural teeth.
   d) The new bridge would replace an existing bridge that is less than five (5) years old, regardless of whether the bridge is serviceable or unserviceable. However, replacement of an unserviceable bridge that is less than five (5) years old is covered if the bridge was provided by a DBP-CA Dental Provider and is determined by DBP to be unserviceable because the diagnosis, treatment, fabrication, or placement rendered by that Provider did not meet applicable standards of dental care.
   e) A bridge would be used only to realign malaligned teeth.
2. A fixed bridge is a benefit to replace missing natural teeth, unless:
   a) The requested service is for a new bridge and a new partial denture in the same arch. In such cases the Covered Service is for a partial denture that would replace all missing teeth in the arch or multiple bridges.
   b) A Member under 16 years of age loses a permanent tooth; in which case an anterior stayplate or space maintainer would be the covered benefit to replace the missing tooth. If the bridge is placed, patient or guardian must pay the dentist's billed charges.
   c) The bridge would be supported in whole or in part by dental implants, or acid-etched resin bridge retainers (a "Maryland" bridge). A bridge would be used only to realign malaligned teeth.
   d) It is a long spanning bridge (anything beyond 4 abutments and/or pontics).
   e) The bridge would have an abutment (support) only on 1 side (cantilever bridge).

C. SINGLE CROWNS, INLAYS AND ONLAYS

Single crowns, inlays and onlays will be covered when there is not enough retentive quality left in a tooth to hold a filling, or if the tooth requires cuspal protection to avoid an unacceptable risk of tooth fracture. The use of specialized materials, i.e., precious or semi-precious metals in crowns, is considered a laboratory upgrade, which the dentist may offer the Member for a fee not to exceed the amount charged to the dentist by the dental laboratory for the upgraded materials. Fees to the Member for upgrades will be limited to the additional laboratory fee charged to the dentist by the dental laboratory for the upgrade. For example, the Provider offers, and the Member accepts, the alternative of a precious (gold) crown instead of a base metal crown. The Provider may charge no more than the listed Copayment for the base metal crown, plus the actual fee charged by the dental laboratory for the use of the precious metal and/or any other specialized material.

1. Porcelain, porcelain-fused-to-metal (PFM), and cast metal crowns are not a benefit for children under 16 years of age. The benefit in such cases is a prefabricated stainless steel or resin crown. If a porcelain, PFM, or cast metal crown is performed, the parent or guardian must pay the Provider's Billed Charges.
2. Replacement of an inlay, onlay, porcelain or PFM crown is a covered benefit as long as the existing restoration is at least five years old, unserviceable and cannot be made serviceable as determined by your Assigned Dental Provider Group. However, replacement of an existing unserviceable inlay, onlay, porcelain, PFM or crown that is less than five years old is covered if the item was provided by a DBP-CA Participating Provider and is determined by DBP-CA to be unserviceable because the diagnosis, treatment, fabrication, or placement rendered by that Provider did not meet applicable standards of dental care.

3. For crowns and fixed bridges, 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.

7. OCCLUSAL EQUILIBRATION – This means the reshaping of the biting surfaces of the teeth to create harmonious contact and relationships between teeth in the upper and lower jaw. Adjustment of the bite on a new restoration, crown, bridge, and denture will be provided at no additional charge if performed by the DBP-CA Participating Provider who provided the restoration service. However, the correction of occlusion on natural teeth or existing restorations is not a Covered Service.
8. DOWEL POSTS AND PINS - Dowel posts are a benefit for teeth that have had root canal therapy and lack sufficient structure to otherwise support and retain a crown. Pins are a separate Covered Service if deemed necessary by a DBP-CA Participating Provider to provide adequate retention of a restoration.
9. SPECIALTY REFERRAL - The BENEFIT of dental treatment by a Specialist is limited to:
   a) Dental plans which include specialty referral benefits
   b) Covered dental services performed by an oral surgeon, endodontist and periodontist that are beyond the scope of practice of a general dentist
   c) Pedodontic referrals apply to all children through age 18 as necessary
   d) Services by an orthodontist, if the Member's Dental Plan specifically includes DBP-CA's orthodontic benefit.

   Specialty Referral Maximum - DBP-CA will not pay more than the specialty family calendar year maximum listed in the Schedule of Benefits, if applicable. Any specialty fees for a family over and above the maximum during a calendar year are not covered by DPB-CA, and are the responsibility of the Member.
10. RESTORATIONS AND DENTAL PROSTHETICS
    a) Restorations and/or fixed or removable prosthetics needed solely to increase vertical dimension or restore the occlusal plane are not Covered Services. To restore the occlusal plane means oral rehabilitation using crown(s), bridge(s), filling(s), and/or denture(s) to establish an altered bite or relationship between the jaws.
    b) B. Composite restorations on posterior teeth may not be a benefit for all plans unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits.
11. I.V. 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. ADJUNCTIVE PRE-DIAGNOSTIC TESTING includes treatment that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures. Limited to 1 per year, to Covered Persons over age 30

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. Specialty referral benefits, unless otherwise indicated in the Schedule of Benefits, are not covered.
2. Services provided by a prosthodontist are not covered.
3. Cosmetic dental care is not covered unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits.
4. 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 Member's Assigned Dental Provider Group, 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*
5. Treatment of fractured bones and dislocated joints is not covered.
6. Lost or stolen dentures are not covered.
7. Crowns or bridgework that are lost, stolen, or damaged due to Member abuse, misuse or neglect are not covered, unless the crown or bridge became dislodged because of recurrent dental caries, tooth fracture, substandard tooth preparation, or poor margins (as previously determined in an examination by the Assigned Dental Provider Group or based upon a review of a pre-existing radiograph).
8. Lost, stolen or broken orthodontic appliances are not covered.
9. Services that are provided to the Member by a state government or agency thereof, or are provided without cost to the Member by a municipality, county or other subdivision are not covered.
10. Charges for services rendered after termination of the Member's eligibility under the Dental Plan are not covered.
11. Work-in-progress: Dental expenses incurred in connection with any portion of the dental services started prior to the effective date of coverage are excluded. The completion of dental or orthodontia services started before the Member's application date or effective date of coverage with DBP-CA, whichever is earlier, or started by a Non-Participating Provider without the prior approval of DBP-CA is not covered. This exclusion does not apply to a current Member:
    a) who has temporary restorative services
    b) whose tooth was opened and medicated while out-of-area or when the assigned dentist is unavailable to render care.
12. The treatment of congenital and/or developmental malformations, which includes the treatment of congenitally missing and extra, supernumerary teeth and related pathology is not covered.
13. The treatment of non-dentigerous cysts, benign and malignant tumors, neoplasms, and dysplasias is not covered.
14. Dental ridge augmentation, vestibuloplasties, and the excision of benign hyperplastic tissue are not covered unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits.
15. Prescription drugs and over-the-counter medicines are not covered.
16. Any dental procedure unable to be performed in the Member's Assigned Dental Provider Group because of the Member's general health and physical limitations is not covered unless an alternative is recommended by the Assigned Dental Provider Group and the Member's physician and authorized by the Plan.
17. Oral surgery and procedures performed in connection with orthodontic treatment, which include, but are not limited to: orthodontic extraction, serial extraction, orthognathic surgery, transeptal fiberotomy, gingivectomy, and surgery to uncover impacted teeth are not covered.
18. Services rendered by a dental office other than the Member's Assigned Dental Provider Group are not covered. An exception is made for Emergency Dental Care, as defined in this Combined Evidence of Coverage and Disclosure Form.
19. The placement, maintenance, and removal of implants, or crowns and fixed prosthetics supported by implants, are not covered.
20. Restorations to replace or stabilize tooth structure lost solely by abrasion or erosion are not covered. Restorations of natural teeth other than those noted herein are not covered. Such treatment includes, but is not limited to, replacing or stabilizing tooth structure loss by abrasion or erosion.
21. Periodontal splinting/grafting is not covered unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits.
22. Amalgam restorations, with new reiterations of a different material solely to eliminate the presence of amalgam are not covered.
23. Restorations and dental prosthetics that are done solely to alter the vertical dimension of occlusion, alter the plane of occlusion, modify a parafunctional habit, and/or treat temporomandibular joint dysfunction and/or myofascial pain syndrome are not Covered Services. If performed, the patient must pay the dentist's Billed Charges unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits. These services include:
    a) Realignment of teeth

b) Gnathologic recording
c) Equilibration
d) Occlusal splints and night guards
e) Overlays, implant supported partial dentures and overdenturess
f) The replacement of otherwise serviceable existing restorations and dental prosthetics
g) Precision attachments and stressbreakers

24. Dental services that the Plan or Participating Provider determines not to be medically necessary or consistent with good professional practice are not covered.
25. Dental services that would not be consistent with the individual Member's dental needs and/or professional recognized standards of dental therapeutics for that Member are not covered.
26. The premature extraction of asymptomatic or non-pathologic impacted teeth at an early stage of tooth development, which, if allowed to further develop and erupt, would reduce the likelihood of needing a more invasive surgery and/or experiencing post-operative complications.
27. Adjunctive dental services that are performed solely to facilitate the performance of another non-Covered Service.
28. Medical services for treatment of fractures, dislocations, tumors, non-dentigerous cysts, and neoplasms, and other medically necessary surgeries of the jaws or related joints are not covered. Requests for such services should be submitted to the Member's full service medical health plan.
29. Relative analgesia (N2O2 - nitrous oxide) is not covered.

Orthodontic Exclusions & Limitations

If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the member will be responsible for all costs associated with any orthodontic treatment.

If you terminate coverage from the DBP-CA Plan after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. The following are not covered orthodontic benefits:
    a) Lost, stolen, or broken appliances
    b) Treatment in progress prior to the effective date of DBP-CA Dental coverage
    c) Extractions required for orthodontic purposes
    d) Surgical orthodontics or jaw repositioning
    e) Myofunctional therapy
    f) Cleft palate
    g) Micrognathia
    h) Macroglossia
    i) Hormonal imbalances
    j) Orthodontic retreatment when initial treatment was rendered under this plan
    k) Palatal expansion appliances
2. If a treatment plan is for less than 24 months, then a prorated portion of the full member copayment shall apply.
3. If member's dental eligibility ends, for whatever reason, and the member is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The member will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
4. If the member has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the member will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist.
5. A member is eligible for only one 24-month orthodontic treatment period while covered under this Plan.
6. One orthodontic benefit under this plan is available per lifetime, per member. A member may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24-month period, the copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24-month benefit period.

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