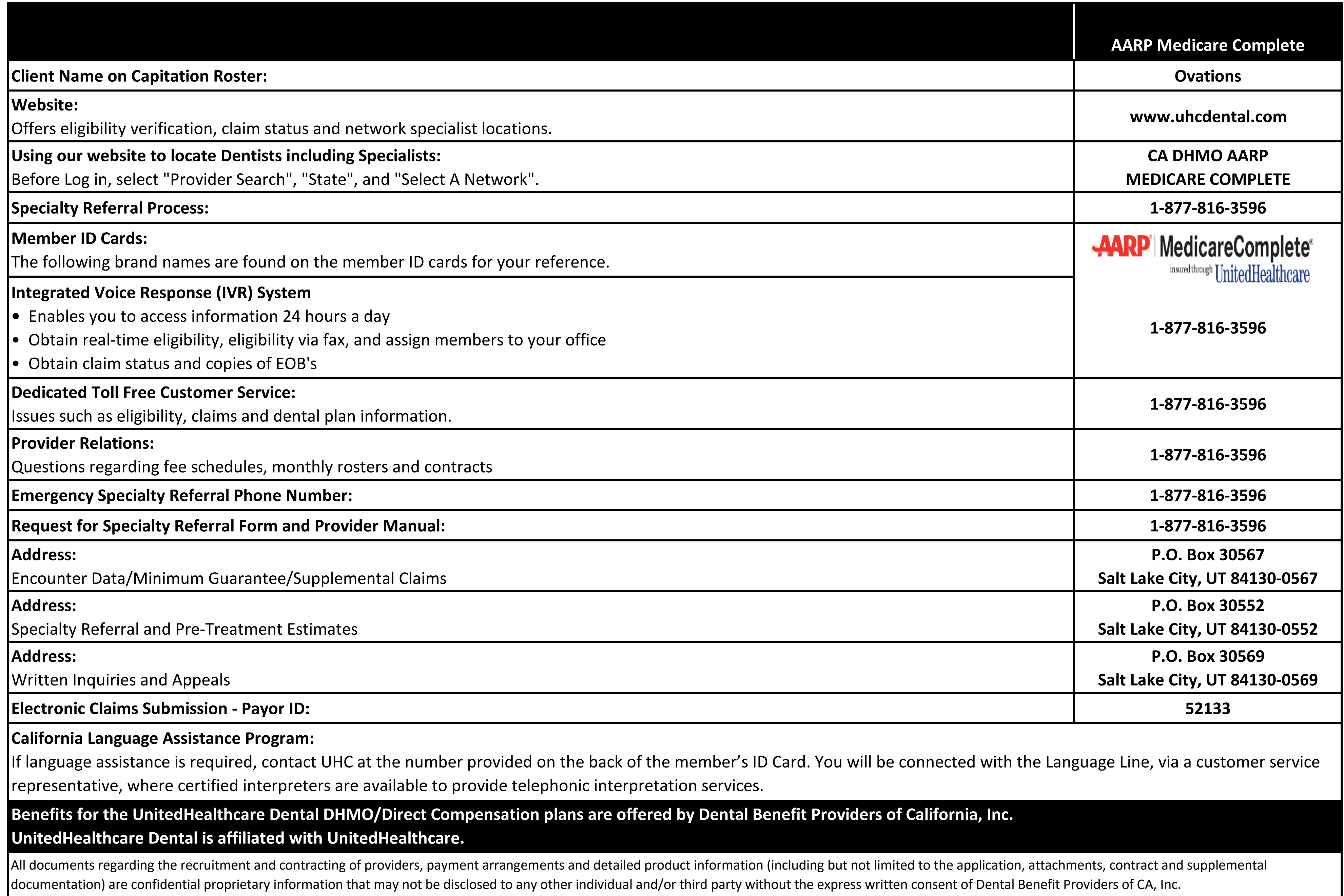
UHC AARP MEDICARE COMPLETE DHMO
QUICK REFERENCE GUIDE (QRG)



	AARP Medicare Complete
Client Name on Capitation Roster:	**Ovations**
Website: Offers eligibility verification, claim status and network specialist locations.	**www.uhcdental.com**
Using our website to locate Dentists including Specialists: Before Log in, select "Provider Search", "State", and "Select A Network".	**CA DHMO AARP MEDICARE COMPLETE**
Specialty Referral Process:	**1-877-816-3596**
Member ID Cards: The following brand names are found on the member ID cards for your reference.	AARP MedicareComplete® insured through UnitedHealthcare
Integrated Voice Response (IVR) System • Enables you to access information 24 hours a day • Obtain real-time eligibility, eligibility via fax, and assign members to your office • Obtain claim status and copies of EOB's	**1-877-816-3596**
Dedicated Toll Free Customer Service: Issues such as eligibility, claims and dental plan information.	**1-877-816-3596**
Provider Relations: Questions regarding fee schedules, monthly rosters and contracts	**1-877-816-3596**
Emergency Specialty Referral Phone Number:	**1-877-816-3596**
Request for Specialty Referral Form and Provider Manual:	**1-877-816-3596**
Address: Encounter Data/Minimum Guarantee/Supplemental Claims	**P.O. Box 30567 Salt Lake City, UT 84130-0567**
Address: Specialty Referral and Pre-Treatment Estimates	**P.O. Box 30552 Salt Lake City, UT 84130-0552**
Address: Written Inquiries and Appeals	**P.O. Box 30569 Salt Lake City, UT 84130-0569**
Electronic Claims Submission - Payor ID:	**52133**

California Language Assistance Program:
If language assistance is required, contact UHC at the number provided on the back of the member's ID Card. You will be connected with the Language Line, via a customer service representative, where certified interpreters are available to provide telephonic interpretation services.

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

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

UHC AARP MEDICARE COMPLETE DHMO
CAPITATION CROSSWALK / PER MEMBER-PER MONTH (PMPM)
EXHIBIT 2

Product ID(s)	Product Name / Client Name	Plan Name / Copayment Schedule	Agreement ID	PMPM Capitation Rate	Minimum Guarantee	Supplemental	Specialty Referral Process	Plan Type
D0012023	AARP Medicare Complete	SH100 Retiree	SFSGD0000002	$0.00	No	Yes*	Not Covered	Medicare
D0028730 - D0028737	AARP Medicare Complete	High Option	SFSGD0000004	$6.15	No	Yes	Prior-Auth	Medicare
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*Encounter Fee Supplemental Only

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UHC AARP MEDICARE COMPLETE
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
EXHIBIT 2

CDT CODE	CDT DESCRIPTION PLAN NAME:	SH 100 Retiree	Hi-Option	Hi-Option Supplemental
	CDT codes not listed are not a covered benefit Agreement ID:	SFSGD0000002	SFSGD0000004	SFSGD0000004
	SPECIALTY REFERRAL PROCESS ($1000 Calendar Year Maximum excluding Orthodontia):	NTCV	PRE-AUTH	
	Encounter Fee Reimbursement: The encounter fee is only reimbursed for covered services on on the same date of service. Please submit CDT Code D0999 with a fee of $2.00 on your encounter claim with all other covered services.	Member Copayment		
D0999	Encounter Fee	0	0	
	Office Visit (see limitation at end of document)	5	5	
	Initial charting with pocket depth summary	10	10	
	Broken Appointment, with no prior notification at least 24 hrs before the scheduled appointment	0	0	
I. DIAGNOSTIC				
D0120	periodic oral evaluation – established patient	8	0	
D0140	limited oral evaluation – problem focused	11	0	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	NTCV	0	
D0150	comprehensive oral evaluation – new or established patient	10	0	
D0160	detailed and extensive oral evaluation – problem focused, by report	12	0	
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)	11	0	
D0171	re-evaluation – post-operative office visit	NTCV	0	
D0180	comprehensive periodontal evaluation – new or established patient	10	0	
D0210	intraoral – complete series of radiographic images	22	0	
D0220	intraoral – periapical first radiographic image	5	0	
D0230	intraoral – periapical each additional radiographic image	3	0	
D0240	intraoral – occlusal radiographic image	6	0	
D0270	bitewing – single radiographic image	5	0	
D0272	bitewings – two radiographic images	9	0	
D0273	bitewings – three radiographic images	NTCV	0	
D0274	bitewings – four radiographic images	11	0	
D0330	panoramic radiographic image	18	0	
D0460	pulp vitality tests	8	0	
II. PREVENTIVE				
D1110	prophylaxis – adult	15	5	
D1206	topical application of fluoride varnish	NTCV	10	
D1208	topical application of fluoride – excluding varnish	NTCV	10	
D1330	oral hygiene instructions	NTCV	0	

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III. RESTORATIVE • If the services of a dental lab are required for any procedure, the member is responsible for the full laboratory cost, not to exceed the actual amount billed by the lab. • If alloy restorations are not provided or offered in the dental practice, payment for the posterior composites is to be based on the amalgam copayment. • Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade. Members 16 years of age and older are limited to 7 crowns and/or pontics in any 12-month period and any single fixed bridge is limited to 4 units in length. The supplemental reimbursement is in addition to this amount.					
D2140	amalgam – one surface, primary or permanent		50	20	
D2150	amalgam – two surfaces, primary or permanent		59	35	
D2160	amalgam – three surfaces, primary or permanent		70	45	
D2161	amalgam – four or more surfaces, primary or permanent		82	60	
D2330	resin-based composite – one surface, anterior		64	30	
D2331	resin-based composite – two surfaces, anterior		75	45	
D2332	resin-based composite – three surfaces, anterior		84	50	
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		94	65	
D2391	resin-based composite – one surface, posterior		66	70	
D2392	resin-based composite – two surfaces, posterior		85	85	
D2393	resin-based composite – three surfaces, posterior		102	105	
D2394	resin-based composite – four or more surfaces, posterior		117	115	
D2510	inlay – metallic – one surface		NTCV	200	
D2520	inlay – metallic – two surfaces		NTCV	200	
D2530	inlay – metallic – three or more surfaces		NTCV	200	
D2542	onlay – metallic – two surfaces		NTCV	200	
D2543	onlay – metallic – three surfaces		NTCV	200	
D2544	onlay – metallic – four or more surfaces		NTCV	200	
D2710	crown – resin-based composite (indirect)		172	125	48
D2712	crown – ¾ resin-based composite (indirect)		172	125	
D2720	crown – resin with high noble metal		438	290	48
D2721	crown – resin with predominantly base metal		385	290	48
D2722	crown – resin with noble metal		438	290	48
D2740	crown – porcelain/ceramic		487	250	48
D2750	crown – porcelain fused to high noble metal		469	275	48
D2751	crown – porcelain fused to predominantly base metal		447	275	48
D2752	crown – porcelain fused to noble metal		455	275	48
D2780	crown – ¾ cast high noble metal		459	250	48
D2781	crown – ¾ cast predominantly base metal		459	250	48
D2782	crown – ¾ cast noble metal		459	250	48
D2783	crown – ¾ porcelain/ceramic		366	200	48
D2790	crown – full cast high noble metal		461	275	48
D2791	crown – full cast predominantly base metal		428	275	48
D2792	crown – full cast noble metal		455	275	48
D2794	crown – titanium		428	275	48

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D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	33	15	
D2920	re-cement or re-bond crown	33	15	
D2931	prefabricated stainless steel crown – permanent tooth	105	40	
D2932	prefabricated resin crown	105	40	
D2940	protective restoration	30	18	
D2941	interim therapeutic restoration – primary dentition	NTCV	18	
D2950	core buildup, including any pins when required	NTCV	65	
D2951	pin retention – per tooth, in addition to restoration	23	10	
D2952	post and core in addition to crown, indirectly fabricated	135	85	
D2953	each additional indirectly fabricated post – same tooth	108	65	
D2954	prefabricated post and core in addition to crown	108	65	
D2957	each additional prefabricated post – same tooth	87	55	
D2971	additional procedures to construct new crown under existing partial denture framework	100	100	
D2975	coping	50	NTCV	
IV. ENDODONTICS • Surgical services include routine post-operative care				
D3110	pulp cap – direct (excluding final restoration)	27	12	
D3120	pulp cap – indirect (excluding final restoration)	45	18	
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	46	20	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	308	165	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	364	225	
D3330	endodontic therapy, molar tooth (excluding final restoration)	490	350	
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	245	150	
D3346	retreatment of previous root canal therapy – anterior	NTCV	245	
D3347	retreatment of previous root canal therapy – premolar	NTCV	280	
D3348	retreatment of previous root canal therapy – molar	NTCV	400	
D3410	apicoectomy – anterior	NTCV	200	
D3421	apicoectomy – premolar (first root)	NTCV	200	
D3425	apicoectomy – molar (first root)	NTCV	200	
D3426	apicoectomy (each additional root)	NTCV	80	
D3430	retrograde filling – per root	NTCV	80	
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	NTCV	80	
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	NTCV	80	
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	NTCV	80	
D3950	canal preparation and fitting of preformed dowel or post	60	0	
V. PERIODONTICS • Surgical services include routine post-operative care				
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	NTCV	180	
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	NTCV	45	

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D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	NTCV	175	
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	NTCV	85	
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	NTCV	500	
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	NTCV	250	
D4341	periodontal scaling and root planing – four or more teeth per quadrant	90	40	
D4342	periodontal scaling and root planing – one to three teeth per quadrant	45	20	
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	50	40	
D4910	periodontal maintenance	54	40	
D4921	gingival irrigation - per quadrant	NTCV	10	

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	VI. PROSTHODONTICS (REMOVABLE) • If the services of a dental lab are required for any procedure, you are responsible for the full laboratory cost, not to exceed the actual amount billed by the lab. • Includes post-delivery care and adjustments for the first 6 months (at the office delivering the removable prosthesis).			
D5110	complete denture – maxillary	528	310	108
D5120	complete denture – mandibular	536	310	108
D5130	immediate denture – maxillary	540	330	108
D5140	immediate denture – mandibular	534	330	108
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	480	150	108
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	477	150	108
D5213	maxillary partial denture – cast mtl framework w/resin denture bases (inc, any conventional clasps, rests/tth)	681	330	108
D5214	mandibular partial denture – cast mtl framework w/resin denture bases (inc, any conventional clasps, rests/tth)	690	330	108
D5225	maxillary partial denture – flexible base (including any clasps, rests and teeth)	480	360	108
D5226	mandibular partial denture – flexible base (including any clasps, rests and teeth)	477	360	108
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	496	275	
D5283	removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	496	275	
D5410	adjust complete denture – maxillary	30	20	
D5411	adjust complete denture – mandibular	30	20	
D5421	adjust partial denture – maxillary	30	20	
D5422	adjust partial denture – mandibular	30	20	
D5511	repair broken complete denture base, mandibular	64	20	
D5512	repair broken complete denture base, maxillary	64	20	
D5520	replace missing or broken teeth – complete denture (each tooth)	54	20	
D5611	repair resin partial denture base, mandibular	69	45	
D5612	repair resin partial denture base, maxillary	69	45	
D5621	repair cast partial framework, mandibular	63	35	
D5622	repair cast partial framework, maxillary	63	35	
D5630	repair or replace broken clasp – per tooth	77	40	
D5640	replace broken teeth – per tooth	60	40	
D5650	add tooth to existing partial denture	78	40	
D5660	add clasp to existing partial denture – per tooth	90	40	
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	341	165	
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	345	165	
D5730	reline complete maxillary denture (chairside)	111	60	
D5731	reline complete mandibular denture (chairside)	108	60	
D5740	reline maxillary partial denture (chairside)	89	60	
D5741	reline mandibular partial denture (chairside)	105	60	
D5750	reline complete maxillary denture (laboratory)	165	100	
D5751	reline complete mandibular denture (laboratory)	158	100	
D5760	reline maxillary partial denture (laboratory)	159	100	
D5761	reline mandibular partial denture (laboratory)	162	100	

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D5850	tissue conditioning, maxillary	NTCV	35	
D5851	tissue conditioning, mandibular	NTCV	35	
D5863	overdenture - complete maxillary	NTCV	310	
D5864	overdenture - complete mandibular	NTCV	310	
D5865	overdenture - partial maxillary	NTCV	330	
D5866	overdenture - partial mandibular	NTCV	330	
VII. MAXILLOFACIAL PROSTHETICS				
• If the services of a dental lab are required for any procedure, the member is responsible for the full laboratory cost, not to exceed the actual amount billed by the lab.				
• Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade. Members 16 years of age and older are limited to 7 crowns and/or pontics in any 12-month period and any single fixed bridge is limited to 4 units in length. The supplemental reimbursement is in addition to this amount.				
D6210	pontic – cast high noble metal	438	275	48
D6211	pontic – cast predominantly base metal	405	275	48
D6212	pontic – cast noble metal	435	275	48
D6214	pontic – titanium	405	275	
D6240	pontic – porcelain fused to high noble metal	455	275	48
D6241	pontic – porcelain fused to predominantly base metal	420	275	48
D6242	pontic – porcelain fused to noble metal	441	275	48
D6245	pontic – porcelain/ceramic	455	275	48
D6250	pontic – resin with high noble metal	487	200	48
D6251	pontic – resin with predominantly base metal	430	200	48
D6252	pontic – resin with noble metal	430	200	48
D6602	retainer inlay – cast high noble metal, two surfaces	NTCV	200	
D6603	retainer inlay – cast high noble metal, three or more surfaces	NTCV	200	
D6604	retainer inlay – cast predominantly base metal, two surfaces	NTCV	200	
D6605	retainer inlay – cast predominantly base metal, three or more surfaces	NTCV	200	
D6606	retainer inlay – cast noble metal, two surfaces	NTCV	200	
D6607	retainer inlay – cast noble metal, three or more surfaces	NTCV	200	
D6624	retainer inlay – titanium	NTCV	200	
D6720	retainer crown – resin with high noble metal	434	200	48
D6721	retainer crown – resin with predominantly base metal	434	200	48
D6722	retainer crown – resin with noble metal	434	200	48
D6740	retainer crown – porcelain/ceramic	487	250	48
D6750	retainer crown – porcelain fused to high noble metal	456	275	48
D6751	retainer crown – porcelain fused to predominantly base metal	438	275	48
D6752	retainer crown – porcelain fused to noble metal	455	275	48
D6780	retainer crown – ¾ cast high noble metal	438	275	48
D6781	retainer crown – ¾ cast predominantly base metal	459	275	48
D6782	retainer crown – ¾ cast noble metal	459	275	48
D6783	retainer crown – ¾ porcelain/ceramic	459	250	48
D6790	retainer crown – full cast high noble metal	455	200	48

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D6791	retainer crown – full cast predominantly base metal	428	200	48
D6792	retainer crown – full cast noble metal	438	200	48
D6794	retainer crown – titanium	428	275	48
D6930	re-cement or re-bond fixed partial denture	43	30	
X. ORAL AND MAXILLOFACIAL SURGERY • Includes local anesthesia, suturing, and routine post-operative care.				
D7111	extraction, coronal remnants – primary tooth	51	25	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	54	25	
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	NTCV	50	
D7220	removal of impacted tooth – soft tissue	NTCV	100	
D7230	removal of impacted tooth – partially bony	NTCV	135	
D7240	removal of impacted tooth – completely bony	NTCV	170	
D7250	removal of residual tooth roots (cutting procedure)	NTCV	90	
D7285	incisional biopsy of oral tissue – hard (bone, tooth)	NTCV	100	
D7286	incisional biopsy of oral tissue – soft	NTCV	100	
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	NTCV	100	
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	NTCV	80	
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	NTCV	150	
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	NTCV	75	
D7471	removal of lateral exostosis (maxilla or mandible)	NTCV	150	
D7472	removal of torus palatinus	NTCV	150	
D7473	removal of torus mandibularis	NTCV	150	
D7485	reduction of osseous tuberosity	NTCV	150	
D7510	incision and drainage of abscess – intraoral soft tissue	65	35	
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	98	50	
D7520	incision and drainage of abscess – extraoral soft tissue	NTCV	50	
D7521	incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	NTCV	60	
XII. ADJUNCTIVE GENERAL SERVICES				
D9110	palliative (emergency) treatment of dental pain – minor procedure	38	0	
D9215	local anesthesia in conjunction with operative or surgical procedures	0	0	
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	NTCV	50	
D9430	office visit for observation (during regularly scheduled hours) – no other services performed	5	5	
D9440	office visit – after regularly scheduled hours	50	30	
D9450	case presentation, detailed and extensive treatment planning	NTCV	30	
D9951	occlusal adjustment – limited	35	15	

OFFICE VISIT LIMITATIONS:

A) The copayment specified in this schedule for office visits is limited to 4 per year, per person. Office visits beyond 4 per year are at no charge. This copayment is due in addition to any other copayment(s) specified for procedures or services rendered.

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B) The fee specified in this schedule for oral examinations is limited to four per year, per member. This fee(s) is due in addition to any other fee(s) specified for procedures or services rendered. Oral examinations beyond four per year are provided at no charge.				
C) For fillings, the office visit copayment is due only once per quadrant, even if fillings are done on separate visits.				
D) For root canals and crowns, the office visit copayment is due only once per procedure, regardless of the number of visits necessary to complete that procedure. For multiple procedures, the office visit copayment is due once for each procedure.				
E) Covered general dental services are unlimited when prescribed and performed by the assigned dental office. A member may be referred to a dental specialist for procedures that are beyond the scope of the general dentist.				

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UHC AARP MEDICARE COMPLETE DHMO
LIMITATION AND EXCLUSIONS OF BENEFITS
EXHIBIT 2

LIMITATION 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. **RADIOGRAPHS** Full Mouth (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, and ONLY two quadrants are allowable at an appoitnment.
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. **OFFICE VISITS**
   A) The copayment fee for an office visit is limited to 4 per year, per member. Office visits beyond 4 per year are provided at no charge.
   B) The office visit for fillings is due only once per quadrant, even oif fillings are done on separate visits.
   C) The office visit fee for root canals and crowns is due only once per procedure, regardless of the number of visits necessary to complete that procedure.
7. **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.
         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 still serviceable.
   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) If an unserviceable existing bridge is less than 5 years old, even if unserviceable, its replacement is not a covered dental service
   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.
   e) It is a long spanning bridge (anything beyond 4 abutments and/or pontics).
   f) The bridge would have an abutment (support) only on 1 side (cantilever bridge).
   g) Fees for upgrades such as precious or semiprecious metal alloys will be limited to the additional fee charged to the network dentist by the dental laboratory for the upgrade

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

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) If a porcelain, PFM or cast metal crown is less than 5 years old, even if unserviceable, its replacement is not a covered dental service
3) Replacement of an inlay, onlay, porcelain or PFM crown is a covered benefit as long as the existing restoration is unserviceable, and can not be made serviceable, as determined by your assigned dentist.
4) 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.
5) Fees for upgrades such as precious or semiprecious metal alloys will be limited to the additional fee charged to the network dentist by the dental laboratory for the upgrade

8. **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 UHC Participating Provider who provided the restoration service. However, the correction of occlusion on natural teeth or existing restorations is not a Covered Service.
9. **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 UHC Participating Provider to provide adequate retention of a restoration.

10. **SPECIALTY REFERRAL** - The BENEFIT of dental treatment by a Specialist is limited to:
    • Dental plans which include specialty referral benefits
    • Covered dental services performed by an oral surgeon, endodontist and periodontist that are beyond the scope of practice of a general dentist
    • Pedodontic referrals apply to all children through age 18 as necessary
    • Services by an orthodontist, if the Member's Dental Plan specifically includes UHC's orthodontic benefit.
    • Specialty Referral Maximum - UHC 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 UHC, and are the responsibility of the Member.
11. **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. Composite restorations on posterior teeth may not be a benefit for all plans. Please refer to your Schedule of Benefits.
12. **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).

EXCLUSION OF BENEFITS

The following procedures and services are excluded and not Covered Services:

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.
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 UHC, whichever is earlier, or started by a Non-Participating Provider without the prior approval of UHC 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.
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.
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. These services include:
    Realignment of teeth
    Gnathologic recording
    Occlusal splints and night guards
    Overlays, implant supported partial dentures and overdentures
    The replacement of otherwise serviceable existing restorations and dental prosthetics
    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.

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

OPTIONAL, UPGRADED OR ALTERNATIVE TREATMENT DISCLOSURE FORM

Patient's Name:	ID:	
Treatment Plan No.:		Chart ID No.:

I. FORMULA for DETERMINING CHARGES for OPTIONAL, UPGRADED or ALTERNATIVE TREATMENT:

When a Member elects a more extensive service that is an alternative to an adequate, but more conservative covered service, please use the following formula to determine the charge:

UCR Fee of Proposed Upgrade [1] - UCR Fee of the Benefit [2] + Copayment for the Benefit [3] =
Accepted Charge for the Proposed Upgrade [4]

			1	2	3	4
CDT Code of Proposed Treatment	Proposed Procedure Description (Indicate reason this is not covered in explanation area below*)	Tooth No. or Area	UCR Fee of Upgrade	UCR Fee of Benefit	Copayment of Benefit	[1] - [2] + [3] = Accepted Charge

II. METAL UPGRADES (for crowns, bridge abutments & pontics)

When a Member elects a laboratory upgrade of a standard covered service, please use the following formula to determine the charge:

Some plans only allow a metal laboratory upgrade charge (e.g. Blue Shield 65 Plus, plans with version 5 Limitations). Metal Upgrades are based on the additional cost of the metal. In these instances please use the following formula to determine the charge:

Copayment [1] + Metal Upgrade [2] = Accepted fee [3]

				1	2	3
CDT Code of Proposed Treatment	Proposed Procedure Description	Tooth No. or Area	UCR Fee of Proposed Treatment	Copayment of Benefit	Additional Charge for Metal Upgrade	Accepted Charge

*Reason for Upgrade / Reason proposed service is not covered:

I agree to the above charges which represent additional financial obligations for treatment or features that I desire that are not part of my dental benefit plan.

Patient's (Parent or Guardian) Signature:	Date:
Treatment Plan presented by DDS:	Date: