UnitedHealthcare®

Texas DHMO Dental Plan

- In Network coverage only (Member must choose and be assigned to an In-Network Provider)
- Deductible – $0
- Annual Maximum - $0
- Orthodontics (Coverage for Children and Adults) – No maximum

Services

Service	Copay	Service	Copay	Service	Copay
Diagnostic	$0	Basic	(See Fee Schedule)	Ortho	(See Fee Schedule)
Preventive	$0	Major	(See Fee Schedule)		

Premiums

Who is Covered	Semi-Monthly	Monthly
Employee only	$0	$0
Employee & Spouse	$1.42	$2.84
Employee & Child(ren)	$2.34	$4.98
Employee & Family	$9.21	$18.42

ADA	DESCRIPTION	MEMBER PAYS[2]
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	$5
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0190	SCREENING OF A PATIENT	$5
D0191	ASSESMENT OF A PATIENT	$5
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$0
D0230	INTRAORL PERIAPICAL EA ADD RADIOGRAPHIC IMAGE	$0
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$0
D0251	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$0
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	$10
D0417	COLLECTION & PREP OF SALIVA SAMPLE	$10
D0418	ANALYSIS OF SALIVA SAMPLE	$10
D0422	COLLECTION AND PREPARATION OF GENETIC SAMPLE MATERIAL FOR LABORATORY ANALYSIS AND REPORT	$0
D0423	GENETIC TEST FOR SUSCEPTIBILITY TO DISEASES - SPECIMEN ANALYSIS	$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
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$0
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$0
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$0
D0999	OFFICE VISIT FEE - PER VISIT	$5
PREVENTIVE SERVICES		
D1110[1]	PROPHYLAXIS - ADULT	$0
D1110[1]	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	$25
D1120[1]	PROPHYLAXIS - CHILD	$0
D1120[1]	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6 MONTHS	$25
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

ADA	DESCRIPTION	MEMBER PAYS[2]
D1330	ORAL HYGIENE INSTRUCTIONS	$0
D1351	SEALANT - PER TOOTH	$8
D1352	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$10
D1353	SEALANT REPAIR – PER TOOTH	$5
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	RECEMENT OR RE-BOND SPACE MAINTAINER	$15
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$15
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED – UNILATERAL	$25
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT	
RESTORATIVE SERVICES		
D2140	AMALGAM-ONE SURFACE PRIMARY/PERM	$0
D2150	AMALGAM-TWO SURFACES PRIMARY/PERM	$0
D2160	AMALGAM-3 SURFACES PRIMARY/PERM	$0
D2161	AMALGAM-FOUR/MORE SURF PRIM/PERM	$0
D2330	RESIN COMPOS - ONE SURFACE ANTERIOR	$0
D2331	RESIN COMPOS - 2 SURFACES ANTERIOR	$0
D2332	RESIN COMPOS - 3 SURFACES ANTERIOR	$0
D2335	RSN COMPOS-4/> SURF/W/INCISAL ANG	$0
D2390	RESIN COMPOS CROWN ANTERIOR	$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

ADA	DESCRIPTION	MEMBER PAYS[2]
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 OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$0
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFAB POST & CORE	$0
D2920	RECEMENT OR RE-BOND CROWN	$0
D2921	REATTACHMENT OF TOOTH FRAGMENT	$65
D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	$80
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
D2934	PREFAB ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	$60
D2940	SEDATIVE FILLING	$0
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$5
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
D2954	PREFABR POST&CORE ADDITION CROWN	$25
D2955	POST REMOVAL	$10
D2957	EA ADD PREFABR POST - SAME TOOTH	$30
D2960	LABIAL VENEER (LAMINATE) - CHAIRSIDE	$295
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$350
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$600
D2971	ADD PROC NEW CROWN XST PART DENTURE	$50
D2975	COPING	$80
D2980	CROWN REPAIR	$35
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$5
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$0
D3120	PULP CAP - INDIRECT	$0
D3220	TX PULPOT-CORONL DENTNOCEMENTL JUNC	$0
D3221	PULPAL DEBRID PRIMARY&PERM TEETH	$30
D3222	PARTIAL PULPOTOMY	$60
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
D3355	PULPAL REGENERATION - INITIAL VISIT	$65
D3356	PULPAL REGENERATION -INTERIM MEDICAMENT REPLACEMENT	$65
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	$65
D3410	APICOECTOMY SURG - ANT	$95
D3421	APICOECTOMY SURG-BICUSPID	$95
D3425	APICOECTOMY SURG - MOLAR	$95
D3426	APICOECTOMY SURGERY	$55
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$250

ADA	DESCRIPTION	MEMBER PAYS[2]
D3430	RETROGRADE FILLING - PER ROOT	$55
D3450	ROOT AMPUTATION - PER ROOT	$95
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$900
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
D4212	GINGIVECT/PLSTY WITH REST PROC/TOOTH	$15
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$150
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$95
D4245	APICALLY POSITIONED FLAP	$165
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 REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	$175
D4263	BONE REPLCMT GRAFT - 1 SITE QUAD	$175
D4264	BN REPLCMT GRAFT - EA ADD SITE QUAD	$90
D4264	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – EACH ADDITIONAL SITE IN QUADRANT	$90
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$225
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	$85
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$85
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$235
D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH	$275
D4320	PROVISIONAL SPLINTING - INTRACORONAL	$75
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$75
D4341	PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	$45
D4342	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	$45
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$25
D4355	FULL MOUTH DEBRID COMP EVAL&DX	$50
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$55
D4910	PERIODONTAL MAINTENANCE	$30
D4920	UNSCHEDULED DRESSING CHANGE	$0
D4921	GINGIVAL IRRIGATION □ PER QUADRANT	$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110	COMPLETE DENTURE - MAXILLARY	$275
D5120	COMPLETE DENTURE - MANDIBULAR	$275
D5130	IMMEDIATE DENTURE - MAXILLARY	$315
D5140	IMMEDIATE DENTURE - MANDIBULAR	$315
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
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$115
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$115
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$115
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$115
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$325

ADA	DESCRIPTION	MEMBER PAYS[2]
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 - PER TOOTH	$30
D5640	REPLACE BROKEN TEETH - PER TOOTH	$30
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$30
D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$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
D5863	OVERDENTURE - COMPLETE MAXILLARY	$425
D5864	OVERDENTURE - COMPLETE MANDIBULAR	$450
D5865	OVERDENTURE - PARTIAL MAXILLARY	$425
D5866	OVERDENTURE - PARTIAL MANDIBULAR	$450
IMPLANT SERVICES		
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$975
D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	$825
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	$220
D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	$930
D6056	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$275
D6057	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$385
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$680
D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$670
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$610
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$585
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$665
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$580
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$585
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$690
D6066*	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN	$660
D6067*	IMPLANT SUPPORTED METAL CROWN	$670
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$655

ADA	DESCRIPTION	MEMBER PAYS[2]
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$660
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$630
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$645
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$635
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$595
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$630
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$615
D6076*	IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD	$680
D6077*	IMPLANT SUPPORTED RETAINER FOR CASE METAL FPD	$630
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$40
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	$180
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$165
D6091	REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT(MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS	$90
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	$60
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$70
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	$530
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$215
D6100	IMPLANT REMOVAL, BY REPORT	$260
D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$240
D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$275
D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	$245
D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$875
D6111	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$875
D6112	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$875
D6113	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$875
D6190		$145
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM	$545
FIXED PROSTHODONTIC SERVICES		
D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	$250
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
D6253	PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$160
D6545	RETAINER- CASE MTL FOR RESIN FXD PROS	$250
D6548	RET-PORC/CER FOR RESIN BONDED FIXED PROS	$300
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	$85

ADA	DESCRIPTION	MEMBER PAYS[2]
D6600	RETAINER INLAY-PORCELAIN/CERAMIC 2 SURFACES	$270
D6601	RETAINER INLAY - PORCELN/CERAMIC 3/MORE SURF	$270
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURF	$175
D6603*	RETAINER INLAY-CAST HI NOBLE METL 3/> SURF	$175
D6604	RETAINER INLAY-CAST PREDOM BASE METL 2 SURF	$175
D6605	RETAINER INLAY-CAST PREDOM BASE METL 3/>SURF	$175
D6606*	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$175
D6607*	RETAINER INLAY - CAST NOBLE METL 3/MORE SURF	$175
D6608	RETAINER ONLAY - PORCELN/CERAMIC 2 SURFACES	$280
D6609	RETAINER ONLAY - PORCELN/CERAMIC 3/MORE SURF	$280
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURF	$175
D6611*	RETAINER ONLAY-CAST HI NOBLE METL 3/> SURF	$175
D6612	RETAINER ONLAY-CAST PREDOM BASE METL 2 SURF	$175
D6613	RETAINER ONLAY-CAST PREDOM BASE METL 3/>SURF	$175
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$175
D6615*	RETAINER ONLAY - CAST NOBLE METL 3/MORE SURF	$175
D6624*	RETAINER INLAY - TITANIUM	$250
D6634*	RETAINER ONLAY - TITANIUM	$250
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$185
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$250
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$250
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	$250
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$300
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$250
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$250
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$250
D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$250
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$250
D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	$250
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$300
D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$250
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$250
D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	$250
D6794*	RETAINER CROWN - TITANIUM	$250
D6920	CONNECTOR BAR	$85
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$0
D6940	STRESS BREAKER	$125
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$60
ORAL SURGERY SERVICES		
D7111	XTRCT CORONL RMNNTS DECIDUOUS TOOTH	$8
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$8
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$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	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$40
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	$150
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$225
D7270	TOOTH REIMPL&/STBL ACC DISPLCD	$50
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$85
D7280	SURGICAL ACCESS AN UNERUPTED TOOTH	$85
D7282	MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	$90
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$150
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$60
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$20

ADA	DESCRIPTION	MEMBER PAYS[2]
D7288	BRUSH BIOPSY	$20
D7290	SURGICAL REPOSITIONING OF TEETH	$75
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
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$215
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$670
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$70
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$110
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$100
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$125
D7471	REMOVAL OF LATERAL EXOSTOSIS	$85
D7472	REMOVAL OF TORUS PALATINUS	$65
D7473	REMOVAL OF TORUS MANDIBULARIS	$65
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$65
D7485	SURGICAL RDUC OSSEOUS TUBEROSITY	$65
D7510	I&D ABSCESS-INTRAORAL SOFT TISS	$35
D7511	I & D ABSC INTRAORAL SOFT TISS COMP	$35
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$70
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$190
D7530	REMO OF FORREIGN BODY - SKIN SUBCUTANEOUS	$40
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	$10
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
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	$0
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$75
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$30
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$70
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$50
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
D9943	OCCLUSAL GUARD ADJUSTMENT	$10
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$30
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$90
D9972	EXTERNAL BLEACHING - PER ARCH PERFORMED IN OFFICE	$125
D9975	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	$125
D9999	BROKEN APPOINTMENT	$20
ORTHODONTIC SERVICES		
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$1,895

ADA	DESCRIPTION	MEMBER PAYS[2]
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$1,895
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$1,895
D8660	PRE-ORTHODONTIC TREATMENT EXAM TO MONITOR GROWTH AND DEVELOPMENT	$250
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	$300
D8999a	a START-UP FEE (INCLUDING EXAM, BEGINNING RECORDS, X-RAYS,TRACING, PHOTOS, AND MODELS)	$150

[1]Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

[2]Copays listed are also applicable in the specialist office.

*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed $150 per unit. If a base metal is used, there are no additional charges from the provider.

UnitedHealthcare/Select Managed Care dental exclusions and limitations

LIMITATIONS OF BENEFITS

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1.	DENTAL PROPHYLAXIS	Limited to 1 time per 6 months
2.	FLUORIDE TREATMENTS	Limited to one time per calendar year
3.	CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
4.	POST AND CORES	Covered only for teeth that have had root canal therapy.
5.	SCALING AND ROOT PLANING	Limited to 4 quadrants per calendar year.
6.	PERIODONTAL MAINTENANCE	Limited to once every 6 months, following active therapy, exclusive of gross debridement
7.	INTRAORAL COMPLETE SERIES (INCLUDING BITEWINGS)	Limited to 1 time in any 2 year period
8.	INTRAORAL BITEWING RADIOGRAPHS	Limited to 1 series of 4 films in any 6 month period
9.	REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (MAJOR RESTORATIVE SERVICES)	Replacement of complete dentures, and fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
10.	CROWNS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
11.	TEMPORARY CROWNS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
12.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
13.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14.	STAINLESS STEEL CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown -primary tooth, are limited to primary anterior teeth.
15.	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 Changes.
16.	ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS	Limited to repairs or adjustments performed more than 6 months after the initial insertion.
17.	INTRAVENOUS SEDATION OR GENERAL ANESTHESIA	Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).
18.	ADJUNCTIVE PRE-DIAGNOSTIC TEST	That aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.

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:

19.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred • In order for specialty services to be Covered by this plan, the following referral process must be followed: • A Covered Person's PCD must coordinate all Dental Services. • When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization... • If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notifi ed of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service. • Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services. • Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.
20.	REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (MINOR RESTORATIVE SERVICES)	Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 years from initial or supplemental placement

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1.	Dental Services that are not Necessary.
2.	Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
3.	Any Dental Procedure not directly associated with dental disease.
4.	Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
5.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
6.	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.
7.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
8.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
10.	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.
11.	Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
12.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
13.	Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
14.	Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of coverage.

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:

15.	Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Primary Care Dentist, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
16.	Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
17.	Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
18.	Dental Services otherwise Covered under the Contract, but rendered after the date individual Coverage under the Contract terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Contract terminates.
19.	Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
20.	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.
21.	Orthodontic Exclusions and 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 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 benefi ts: • Extractions required for orthodontic purposes • Surgical orthodontics or jaw repositioning • Myofunctional therapy • Cleft palate • Micrognathia • Macroglossia • Hormonal imbalances • Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of accident • Palatal expansion appliances • Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person 2. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply. 3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person 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 Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist. 4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist. 5. One orthodontic benefi t under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefi t 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 fi rst 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefi t period.
22.	Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization