PINNACLE PLAN

COLORADO Sample Copayment Schedule

This dental plan is underwritten by United Dental Care of Colorado, Inc.

1. Plan Dentist Services

The dental services listed on the Copayment Schedule below are covered only when provided by the Member's selected Plan Dentist. Dental services that do not appear on this list are not covered by the plan. Members will be responsible for paying the amount listed in the "Member Copayment" column at the time the service is received, or in accordance with the Plan Dentist's billing procedures.

Except in the case of covered dental emergency services, payment for all services received from a Non-Plan Dentist will be the responsibility of the Member.

2. Plan Specialist Services

Should Member require dental services that his selected Plan Dentist is unable to provide, he may obtain those services from a Plan Specialist at a discounted rate. No referral is needed from the selected Plan Dentist in order for Member to obtain services from Plan Specialist. There is no applicable copayment schedule for Plan Specialist services. Instead, the following discounts will apply. A 15% discount off that Plan Specialist's normal retail charges will be applied to charges obtained from a Plan Specialist who is an Endodontist. A 25% discount off the Plan Specialist's normal retail charges will be applied to all other services (including orthodontic services) received from a Plan Specialist. Member will be responsible for paying the entire discounted charge at the time the service is received, or in accordance with the Plan Specialist's billing procedures. Members covered by a Specialty Benefit Amendment may have some specialty services covered by a copayment schedule. Please consult your Copayment Schedule with Specialty Benefits for complete details.

Except in the case of covered dental emergency services, payment for all services received from a Non-Plan Specialist will be the responsibility of the Member.

ADA Code	Plan Dentist Treatment	Member Copayment
	Appointments	
999	Routine Office Visit	5.00
120	Periodic Oral Evaluation	No Charge
150	Comprehensive Oral Evaluation	No Charge
140	Limited Oral Evaluation – Problem Focused (emergency office visit, normal hours)	20.00
9440	Emergency Office Visit (after regularly scheduled office hours)	40.00
9999	Missed Appointment without 24-Hour Notice	20.00
	Diagnostic Dentistry	
210	X-Ray - Intraoral, Complete Series, Including Bitewings	No Charge
220	X-Ray - Intraoral, Periapical, First Film	No Charge
230	X-Ray - Intraoral, Periapical, Each Additional Film	No Charge
240	X-Ray - Intraoral, Occlusal Film	No Charge
250	X-Ray - Extraoral, First Film	No Charge
260	X-Ray - Extraoral, Each Additional Film	No Charge
270	X-Ray - Bitewing Single Film	No Charge
272	X-Ray - Bitewing Two Films	No Charge
274	X-Ray - Bitewing Four Films	No Charge
330	X-Ray - Panoramic Film	No Charge
415	Bacterial Studies	No Charge
425	Caries Susceptibility Tests	No Charge
460	Pulp Vitality Tests	No Charge
	Preventive Dentistry	
1110	Routine Prophy/Cleaning - Adult (once every 6 mos.)	No Charge
1120	Routine Prophy/Cleaning - Child up to age 18 (once every 6 mos.)	No Charge
1203	Topical Application of Fluoride - Child up to age 18 (Prophy/cleaning not included)	No Charge
1310	Nutritional Counseling	No Charge
1330	Oral Hygiene Instruction	No Charge
1351	Application of Sealant, Per Tooth	5.00
1510	Space Maintainer (Fixed) - Unilateral*	60.00
1515	Space Maintainer (Fixed) - Bilateral*	60.00
1520	Space Maintainer (Removable) - Unilateral*	60.00
1525	Space Maintainer (Removable) - Bilateral*	60.00
1550	Recement Space Maintainer	5.00
1999	Additional Routine Prophy/Cleaning (Routine cleaning does not apply to patients with periodontal disease)	20.00
	Restorative Dentistry (Fillings/Crowns)	
2110	Amalgam - One Surface, Primary	8.00
2120	Amalgam - Two Surfaces, Primary	9.00
2130	Amalgam - Three Surfaces, Primary	10.00
2131	Amalgam - Four or More Surfaces, Primary	15.00
2140	Amalgam - One Surface, Permanent	10.00
2150	Amalgam - Two Surfaces, Permanent	15.00
2160	Amalgam - Three Surfaces, Permanent	20.00
2161	Amalgam - Four or More Surfaces, Permanent	25.00
2330	Resin Filling - One Surface, Anterior	15.00
2331	Resin Filling - Two Surfaces, Anterior	20.00
2332	Resin Filling - Three Surfaces, Anterior	25.00
2335	Resin Filling - Four or More Surfaces, Anterior	40.00
2385	Resin Filling - One Surface, Posterior, Permanent	25.00
2386	Resin Filling - Two Surfaces, Posterior, Permanent	35.00
2387	Resin Filling - Three or More Surfaces, Posterior, Permanent	45.00
2510	Inlay - Metallic, One Surface*	115.00
2520	Inlay - Metallic, Two Surfaces*	140.00
2530	Inlay - Metallic, Three or More Surfaces*	210.00
2543	Onlay - Metallic, Three Surfaces*	175.00
2544	Onlay - Metallic, Four or More Surfaces*	185.00
2610	Inlay - Porcelain/Ceramic, One Surface*	175.00
2620	Inlay - Porcelain/Ceramic, Two Surfaces*	185.00
2630	Inlay - Porcelain/Ceramic, Three or More Surfaces*	185.00
2740	Crown - Porcelain/Ceramic*	225.00
2750	Crown - Porcelain Fused to High Noble Metal*	225.00
2751	Crown - Porcelain Fused to Base Metal*	225.00
2752	Crown - Porcelain Fused to Noble Metal*	225.00
2790	Crown - Full Cast High Noble Metal*	225.00
2791	Crown - Full Cast Base Metal*	225.00
2792	Crown - Full Cast Noble Metal*	225.00
2810	Crown - 3/4 Cast Metallic*	225.00
2910	Recement Inlay	5.00
2920	Recement Crown	5.00
2930	Prefabricated Stainless Steel Crown - Primary Tooth	55.00
2940	Sedative Filling	10.00
2950	Core Buildup, Including Any Pins	20.00
2951	Pin Retention - Per Tooth in Addition to Restoration	10.00
2952	Cast Post and Core, in Addition to Crown*	80.00
2954	Prefabricated Post and Core, in Addition to Crown	50.00
2960	Labial Veneer (Laminate) - Chairside	260.00
2962	Labial Veneer (Porcelain Laminate) – Lab*	315.00

*Members are responsible for additional lab fees for these services.

See Other Side

ADA Code	Plan Dentist Treatment	Member Copayment
2980	Repair Crown*	15.00
2999	Temporary Filling	10.00
2999	Cosmetic Bleaching, Per Arch	150.00
2999	Cosmetic Bleaching, Both Arches	300.00
	Endodontics (Root Canals)	
3110	Pulp Cap - Direct	12.00
3120	Pulp Cap - Indirect	6.00
3220	Pulpotomy	25.00
3310	Root Canal - Anterior (excluding final restoration)	110.00
3320	Root Canal - Bicuspid (excluding final restoration)	130.00
3330	Root Canal - Molar (excluding final restoration)	190.00
3346	Retreatment of Previous Root Canal Therapy - Anterior.	210.00
3347	Retreatment of Previous Root Canal Therapy - Bicuspid.	300.00
3348	Retreatment of Previous Root Canal Therapy - Molar	350.00
3410	Apicoectomy - Anterior	100.00
3421	Apicoectomy - Bicuspid, First Root	100.00
3425	Apicoectomy - Molar, First Root	100.00
3426	Apicoectomy - Each Additional Root	75.00
3430	Retrograde Filling - Per Root	30.00
3450	Root Amputation - Per Root	50.00
3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	40.00
	Periodontics	
4210	Gingivectomy or Gingivoplasty, Per Quadrant	150.00
4220	Gingival Curettage, Per Quadrant	45.00
4260	Osseous Surgery, Per Quadrant	275.00
4320	Provisional Splinting Intracoronal	60.00
4321	Provisional Splinting Extracoronal	40.00
4341	Periodontal Scaling and Root Planing, Per Quadrant	40.00
4355	Full Mouth Debridement (Complicated Cleaning)	30.00
4910	Periodontal Maintenance Procedures	25.00
4999	Periodontal Hygiene Instruction	No Charge
4999	Periodontal Charting for Planning Treatment of Periodontal Disease	8.00
	Removable Prosthodontics (Dentures)	
5110	Complete Upper Denture*	300.00
5120	Complete Lower Denture*	300.00
5130	Immediate Upper Denture (Excluding Reline)*	300.00
5140	Immediate Lower Denture (Excluding Reline)*	300.00
5211	Partial Denture - Upper Resin Base, Including Clasps, etc.*	310.00
5212	Partial Denture - Lower Resin Base, Including Clasps, etc.*	310.00
5213	Partial Denture - Upper Cast Metal Framework/Acrylic Base*	310.00
5214	Partial Denture - Lower Cast Metal Framework/Acrylic Base*	310.00
5410	Adjust Complete Denture - Upper	10.00
5411	Adjust Complete Denture - Lower	10.00
5421	Adjust Partial Denture - Upper	10.00
5422	Adjust Partial Denture - Lower	10.00
5510	Repair Broken Complete Denture Base*	30.00
5610	Repair Resin Denture Base*	25.00
5620	Repair Cast Framework*	30.00
5630	Repair or Replace Broken Clasps	40.00
5640	Repair Broken Teeth - Per Tooth	35.00
5650	Add Tooth to Existing Partial Denture	40.00
5730	Reline Complete Upper Denture - Chairside	50.00
5731	Reline Complete Lower Denture - Chairside	50.00
5740	Reline Upper Partial Denture - Chairside	50.00
5741	Reline Lower Partial Denture - Chairside	50.00
5750	Reline Complete Upper Denture - Lab*	75.00

ADA Code	Plan Dentist Treatment	Member Copayment
5751	Reline Complete Lower Denture - Lab*	75.00
5760	Reline Upper Partial Denture - Lab*	75.00
5761	Reline Lower Partial Denture - Lab*	75.00
5850	Tissue Conditioning - Upper Denture	15.00
5851	Tissue Conditioning - Lower Denture	10.00
5862	Precision Attachment, by Report*	80.00
	Fixed Prosthodontics	
6210	Pontic - Cast High Noble Metal, Per Unit*	225.00
6211	Pontic - Cast Base Metal, Per Unit*	225.00
6212	Pontic - Cast Noble Metal, Per Unit*	225.00
6240	Pontic - Porcelain Fused to High Noble Metal, Per Unit*	225.00
6241	Pontic - Porcelain Fused to Base Metal, Per Unit*	225.00
6242	Pontic - Porcelain Fused to Noble Metal, Per Unit*	225.00
6251	Pontic - Resin with Base Metal, Per Unit*	225.00
6545	Resin Bonded Retainer, Per Unit*	120.00
6721	Crown - Resin with Base Metal, Per Unit*	225.00
6750	Crown - Porcelain Fused to High Noble Metal, Per Unit*	225.00
6751	Crown - Porcelain Fused to Base Metal, Per Unit*	225.00
6752	Crown - Porcelain Fused to Noble Metal, Per Unit*	225.00
6780	Crown - 3/4 Cast High Noble Metal, Per Unit*	225.00
6790	Crown - Full Cast High Noble Metal, Per Unit*	225.00
6791	Crown - Full Cast Base Metal, Per Unit*	225.00
6792	Crown - Full Cast Noble Metal, Per Unit*	225.00
6930	Recement Bridge	10.00
6940	Stress Breaker	60.00
6950	Precision Attachment	130.00
6980	Bridge Repair*	35.00
6999	Resin Bonded Bridge Pontic, Per Unit*	160.00
	Oral Surgery	
7110	Single Tooth Extraction	10.00
7120	Each Additional Tooth Extraction, Per Visit	10.00
7130	Root Removal - Exposed Roots	20.00
7210	Surgical Removal of Erupted Tooth	30.00
7220	Removal of Impacted Tooth - Soft Tissue	50.00
7230	Removal of Impacted Tooth - Partial Bony	70.00
7240	Removal of Impacted Tooth - Complete Bony	90.00
7241	Removal of Impacted Tooth - Complete Bony, with Complications	75.00
7250	Surgical Removal of Residual Roots (Cutting Procedure)	35.00
7270	Tooth Reimplantation/Stabilization	60.00
7281	Surgical Exposure, Per Tooth	55.00
7310	Alveoloplasty in Conjunction With Extractions, Per Quadrant	50.00
7320	Alveoloplasty Not in Conjunction with Extractions, Per Quadrant	70.00
7470	Removal of Exostosis	85.00
7510	Incision and Drainage of Abscess - Intraoral	30.00
7910	Suture of Small Wound up to 5 cm.	50.00
7960	Frenectomy	70.00
	Other Services	
9220	General Anesthesia (first 30 minutes)	180.00
9230	Analgesia - Nitrous Oxide (per 30 minutes)	6.00
9240	IV Sedation	180.00
9310	Consultation Appoint.	25.00
9940	Occlusal Guards	115.00
9951	Occlusal Adjustment - Limited	25.00
9952	Occlusal Adjustment - Complete	75.00

This is a Sample Member Copayment Schedule only. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement and Evidence of Coverage, which determines all rights, benefits, and applicable Limitations and Exclusions.

*Members are responsible for additional lab fees for these services.