PLAN DENTAL 1-2

UNIDENT

TIJUANA

PASEO RIO TIJUANA 406
3er PISO (3rd FLOOR)
EDIFICIO SIMNSA
TIJUANA, B.C.
Tel: 979-2201, 979-2203 ó 979-2204 ó 979-2199
Lunes-Viernes 8 A.M. – 8 P.M.
Sábado 8 A.M. – 5 P.M. Domingo 10 A.M.-2P.M.

MEXICALI

Calle E # 123 col. Segunda Sección C.P. 21100
Entre Madero y Callejón Madero
TEL. (686) 555-6322 Horario: Lunes a Viernes de 8:00 A.M. a 8:00 P.M. Sábados 8:00 A.M. a 4:00 P.M. Y Domingos de 10:00 a. m. a 2:00 p. m.

COVERED SERVICES		CO-PAY
DIAGNOSTIC AND PREVENTIVE SERVICES		
01100	Oral examination, diagnostic, consultation	No Charge
01120	Office visit & periodic oral examinations	No Charge
01130	Emergency oral examinations	No Charge
01210	Complete series x-rays	No Charge
	Infection control - per visit	No Charge
00220	Single periapical film	No Charge
00230	Each additional film	No Charge
00460	Pulp vitality tests	No Charge
	Teeth cleaning (prophylaxis-treatment to include basic	
scaling	and polishing/eligible every six months):	No Charge
01110 Adult		No Charge
01120 Child		No Charge
01203	Topical fluoride (up to age 18)	No Charge
SPACE MAINTAINERS:		
01510 Unilateral	fixed	$20.00
01520 Unilateral	removable	25.00
08210	Removable appliance therapy (thumb-sucking appliance)	25.00
AMALGAM RESTORATIONS, PRIMARY TEETH:		
02110	Cavities involving one tooth surface	$ 5.00
02120	Cavities involving two tooth surfaces	8.00

02130	Cavities involving three surfaces	10.00

AMALGAM RESTORATIONS, PERMANENT TEETH:

02140	Cavities involving one tooth surface	$ 5.00
02150	Cavities involving two tooth surfaces	8.00
02160	Cavities involving three tooth surfaces	10.00
02161	Cavities involving four or more tooth surfaces	10.00
02210	Silicate cement - per restoration	15.00
02330	Acrylic or plastic restoration (Anterior teeth)	15.00

RESIN RESTORATIONS (POSTERIOR TEETH ONLY)

2330	Resin-one surface	24.00
2331	Resin-two surfaces	30.00
2332	Resin-th ree surfaces	34.00
2333	Resin-four or more surfaces	37.00
2210	Silicate cement- per restoration	15.00

CROWNS - PER UNIT: PLUS ADDITIONAL COST OF NOBLE METAL (GOLD)

02740	Porcelain (molars not included)	$50.00
02751	Porcelain with non-precious metal (molars not included)	50.00
02753	Acrylic	45.00
02754	Acrylic with metal	45.00
02791	Full cast non-precious metal	15.00
02810	3/4 Crown	50.00
02910	Recem ent inlay	5.00
02920	Recem ent crown	5.00
02930	Prefabricated stainless steel crown - primary	15.00
02931	Prefabricated stainless steel crown - permanent	15.00
02950	Pin build-up	45.00
02952	Cast metal post	45.00

ENDODONTICS

03110	Pulp capping direct (no final restoration)	$ 5.00
03120	Pulp cap indirect (no final restoration)	10.00
03220	Vital pulpotomy	10.00
03310	1 canal	30.00
03320	2 canals	40.00
03330	3 canals	50.00

03410	Apicoectomy/anterior (per root) (periapical)	50.00
03411	Apicoectomy/per tooth, each additional root	50.00
03940	Recalcification	5.00
03999	Culturing canal	5.00

PERIODONTICS:

09110	Palliative (emergency) treatment	$ 7.00
04210	Gingivectomy/gingivoplasty - per quadrant	25.00
04211	Gingival or gingivoplasty, per tooth	8.00
04220	Gingival curettage - per quad	18.00
04250	Mucogingival surgery - per quad	36.00
04260	Osseous surgery - per quad	36.00

PROSTHETICS:

05110	Complete upper	$63.00
05120	Complete lower	63.00
05211	Upper partial - resin base (including any conventional clasps, rests and teeth)	63.00
05212	Lower partial - resin base (including any conventional clasps, rests and teeth)	63.00
05213	Partial upper - cast metal with resin saddles (include any conventional clasps, rests and teeth)	63.00
05214	Partial lower - cast metal base with resin saddles (include any conventional clasps, rests & teeth)	63.00
05410	Adjust complete denture - upper	10.00
05411	Adjust complete denture - lower	10.00
05421	Adjust partial denture - upper	10.00
05422	Adjust partial denture - lower	10.00
05510	Repair broken complete denture base	15.00
05520	Replace missing or broken teeth	10.00
05610	Repair resin acrylic saddle or base	20.00
05630	Repair or replace broken clasp	20.00
05640	Replace broken teeth - per tooth	10.00
05650	Add tooth to existing partial denture (first tooth)	15.00
	Each additional tooth	5.00
05660	Add clasp to existing partial denture	5.00
05730	Reline complete upper denture (Chairside)	15.00

05731	Reline complete lower denture (Chairside)	15.00
05740	Reline upper partial denture (Chairside)	15.00
05741	Reline lower partial denture (Chairside)	15.00
05750	Reline complete upper denture (Laboratory)	18.00
05751	Reline complete lower denture (Laboratory)	18.00
05760	Reline upper partial denture (Laboratory)	18.00
05761	Reline lower partial denture (Laboratory)	18.00
	Reconstruction (jump per denture, including impression)	35.00
05820	Stayplate - upper or lower	10.00
06940	Stressbreakers	15.00

BRIDGES - PER UNIT (PLUS ADDITIONAL COST OF NOBLE METAL)

06211	Pontic - Cast predominantly base metal	$60.00
06241	Pontic - Porcelain fused to predominantly base metal	70.00
06251	Pontic - Resin with predominantly base metal	60.00
06930	Recem ent bridge	10.00
05281	Re movable (unilateral) bridges:	
	One piece casting, per unit	15.00
Steel	facing	50.00

ORAL SURGERY:

07110	Single tooth	$ 8.00
07120	Each additional tooth	8.00
07210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone/or section of tooth	15.00
07220	Removal of impacted tooth - Soft tissue	30.00
07230	Removal of impacted tooth - Partially bony	35.00
07240	Removal of impacted tooth - Completed bony	50.00
07285	Biopsy of oral tissue - Hard	No Charge
07286	Biopsy of oral tissue - Soft	No Charge
07310	Alveoplasty in conjunction with extractions per quadrant	15.00
07960	Frenulectomy (Frenectomy or Frenotomy) - separate procedure	25.00
07510	Incision and drainage of abscess-intraoral soft tissue	No Charge

ADJUNCTIVE GENERAL SERVICES

09110	Palliative (Emergency) treatment of dental pain	$ 5.00
09215	Local anesthesia	No Charge
09241	Sedative base	No Charge

09310	Consultation (Diagnostic service provided by dentist other than practitioner providing treatment)	No Charge
09430	Post operative visit	No Charge
09440	Office visit - after regularly scheduled hours	10.00
09999	Broken appointment (Less than 24-hour notice)	10.00

ORTHODONTICS:

03000	Full banded case - adult	$50.00 copay/visit*
03001	full banded case - child	$50.00 copay/visit*

* Orthodontic lenghts of treatment are normally 24 months ; However some may extend or conclude sooner, the copayment shall be paid each time the patient is requiered to receive service for the orthodontic treatment which is usually once a month. Additional charges may apply in case of patient negligence with installed braces. Metal brackets included. Cosmetic brackets not covered.

Exclusions & Limitations

a. Services which, in the opinion of the attending dentist are not necessary for the patient's dental health. In all cases where the patient selects a plan of treatment that is considered unnecessary by the attending dentist, any additional cost is the responsibility of the patient;

b. Implants;

c. Aesthetics - services for appearance only, or to correct congenital conditions;

d. Myofunctional therapy - procedures for training, treating or developing muscles in and around the jaw or mouth;

e. Treatment for malignancies or neoplasms (tumors);

f. Dispensing of drugs not normally supplied in dental office;

g. Any dental procedure or service rendered while patient is hospitalized;

h. Prosthodontics - replacement will be made of an existing appliance (dentures, etc.) only if it is unsatisfactory. Prosthodontic appliances will be replaced only after five years have elapsed from the time of delivery. Lost or stolen appliances are the responsibility of the member;

i. Service compensable under Worker's Compensation or Employer's Liability Laws may be subject to reimbursement;

j. Services provided or paid by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. The exception extends to any benefits provided under the U.S. Social Security Act and its Amendments;

k. Charges for services provided for temporomandibular joint (TMJ) dysfunctions;

l. Charges for services prior to the date the person became covered and was eligible for benefits under this plan, or for charges "incurred" following termination of coverage;

m. Non-emergency services rendered by any nonparticipating dentist;

n. Procedures, appliances, or restoration that are necessary to alter occlusion, or a full mouth rehabilitation..