


**HEALTH NET OF CALIFORNIA / CENTENE DHMO
QUICK REFERENCE GUIDE (QRG)**



Client Name on Capitation Roster:	HEALTH NET, INC - CALIFORNIA CENTENE
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".	HEALTH NET DHMO CA ONLY
Specialty Referral Process: Pre-Authorization: General Dentist must obtain preauthorization for all specialty services. Direct Referral: General Dentist may directly refer a patient to any participating specialist. Self Referral: Member may self-refer to any participating specialist.	Pre-Authorization, Direct or Self Referral (Refer to copay schedule)
Member ID Cards: The following brand names are found on the member id cards for your reference.	
Integrated Voice Response (IVR) System: <ul style="list-style-type: none"> 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 	1-866-249-2382
Dedicated Toll Free Customer Service: Issues such as eligibility, claims and dental plan information.	1-866-249-2382
Provider Relations: Questions regarding fee schedules, monthly rosters and contracts	1-866-249-2382
Emergency Specialty Referral Phone Number:	1-866-249-2382
Address: Encounter Data, Minimum Guarantee/Supplemental Claims	P.O. Box 30567 Salt Lake City, UT 84130-0567
Specialty Referral and Pre-Treatment Estimates	P.O. Box 30552 Salt Lake City, UT 84130-0552
Written Inquiries and Appeals	P.O. Box 30569 Salt Lake City, UT 84130-0569
Electronic Claims Submission - Payor ID:	52133
Request for Specialty Referral Form and Provider Manual:	1-866-249-2382
California Language Assistance Program: If language assistance is required, contact DBP-CA at the number provided on the back of the member's ID Card. You will then 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.

**HEALTH NET OF CALIFORNIA / CENTENE DHMO
CAPITATION CROSSWALK / PER MEMBER-PER MONTH (PMPM)**



EXHIBIT 2-A-ii

Product Name / Client Name	Plan Name / Copayment Schedule	Product ID	Agreement ID	PMPM Capitation Rate	Minimum Guarantee	Specialty Referral Process	Plan Type
Health Net of CA	HN Value DHMO 50	D0005611	SCFG00000189	\$4.60	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 50	D0005612	SCFG00000189	\$4.60	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 85	D0005633	SCFG00000190	\$4.00	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 85	D0005634	SCFG00000190	\$4.00	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 115	D0005625	SCFG00000191	\$3.74	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 115	D0005626	SCFG00000191	\$3.74	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 115	D0005627	SCFG00000191	\$3.74	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 115	D0005628	SCFG00000191	\$3.74	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 150	D0005629	SCFG00000192	\$3.22	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 150	D0005630	SCFG00000192	\$3.22	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 150	D0005631	SCFG00000192	\$3.22	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 150	D0005632	SCFG00000192	\$3.22	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 175	D0005621	SCFG00000193	\$3.01	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 175	D0005622	SCFG00000193	\$3.01	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 175	D0005623	SCFG00000193	\$3.01	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 175	D0005624	SCFG00000193	\$3.01	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 225	D0005617	SCFG00000194	\$2.79	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 225	D0005618	SCFG00000194	\$2.79	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 225	D0005619	SCFG00000194	\$2.79	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 225	D0005620	SCFG00000194	\$2.79	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 275	D0005613	SCFG00000195	\$2.64	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 275	D0005614	SCFG00000195	\$2.64	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 275	D0005615	SCFG00000195	\$2.64	Yes	Pre-Auth	Commercial
Health Net of CA	HN Value DHMO 275	D0005616	SCFG00000195	\$2.64	Yes	Pre-Auth	Commercial
Health Net of CA	HN Plus DHMO 85	D0005597	SCFG00000196	\$3.58	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 85	D0005604	SCFG00000196	\$3.58	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 85	D0011162	SCFG00000196	\$3.58	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 100	D0005602	SCFG00000197	\$3.52	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 100	D0005605	SCFG00000197	\$3.52	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0005599	SCFG00000198	\$3.46	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0005603	SCFG00000198	\$3.46	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0005606	SCFG00000198	\$3.46	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0005607	SCFG00000198	\$3.46	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0012372	SCFG00000198	\$3.46	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0015937	SCFG00000198	\$3.46	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0015946	SCFG00000198	\$3.46	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 185	D0005601	SCFG00000199	\$3.35	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 185	D0005608	SCFG00000199	\$3.35	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0005598	SCFG00000200	\$3.30	Yes	Direct	Commercial

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CAPITATION CROSSWALK / PER MEMBER-PER MONTH (PMPM)**



EXHIBIT 2-A-ii

Product Name / Client Name	Plan Name / Copayment Schedule	Product ID	Agreement ID	PMPM Capitation Rate	Minimum Guarantee	Specialty Referral Process	Plan Type
Health Net of CA	HN Plus DHMO 225	D0005600	SCFG00000200	\$3.30	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0005609	SCFG00000200	\$3.30	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0005610	SCFG00000200	\$3.30	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0011399	SCFG00000200	\$3.30	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0012373	SCFG00000200	\$3.30	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0015604	SCFG00000200	\$3.30	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0015939	SCFG00000200	\$3.30	Yes	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0015945	SCFG00000200	\$3.30	Yes	Direct	Commercial
Health Net of CA	HN FB DHMO	D0005687	SCFG00000201	\$2.83	Yes	Direct	Commercial
Health Net of CA	HN FB DHMO Preferred	D0005681	SCFG00000202	\$2.60	Yes	Self	Commercial
Health Net of CA	HN Group Plan 90-SD	D0005636	SCFG00000203	\$2.99	Yes	Direct	Commercial
Health Net of CA	HN HN2009	D0005654	SCFG00000204	\$3.72	Yes	Direct	Commercial
Health Net of CA	HN Gemini DHMO 50-S	D0005635	SCFG00000205	\$4.22	Yes	Pre-Auth	Commercial
Centene	HN IFP DHMO Adult Buy Up	D0013661	SCFG00000206	\$1.51	Yes	Pre-Auth	Commercial
Health Net of CA	Buy Up Group	D0005644	SCFG00000207	\$2.00	No	Direct	Medicare
Health Net of CA	DHMO Group Med Supp Buy Up	D0011129	SCFG00000207	\$2.00	No	Direct	Medicare
Centene	HN DHMO Medicare Supp Buy Up	D0005662	SCFG00000208	\$3.50	No	Direct	Medicare
Centene	HN SNP RMC DHMO Supp	D0005663	SCFG00000208	\$3.50	No	Direct	Medicare
Centene	HN Medicare Supp Buy Up Ruby	D0009500	SCFG00000208	\$3.50	No	Direct	Medicare
Health Net of CA	HN DHMO Medicare Supp Buy Up Salud	D0009501	SCFG00000208	\$3.50	No	Direct	Medicare
Health Net of CA	HN Custom CV DHMO Grp Ret	D0005668	SCFG00000211	\$1.75	No	Direct	Commercial
Health Net of CA	Boeing DHMO Buy Up Group	D0011500	SCFG00000219	\$2.00	No	Direct	Medicare
Health Net of CA	HN Value DHMO 115 (UC Post)	D0012811	SCFG00000221	\$3.74	Yes	Pre-Auth	Commercial
Centene	Jade and Amber SNP CHF Core Plan	D0011953	SCFG00000285	\$3.50	Yes	Direct	Medicare
Centene	Jade and Amber SNP CHF Core Plan	D0016391	SCFG00000285	\$3.50	Yes	Direct	Medicare
Centene	Jade and Amber SNP CHF Core Plan	D0016392	SCFG00000285	\$3.50	Yes	Direct	Medicare
Centene	Medicare DHMO Plan	D0019968	SCFG00000285	\$3.50	Yes	Direct	Medicare
Centene	Medicare DHMO Plan	D0019969	SCFG00000285	\$3.50	Yes	Direct	Medicare
Centene Health Net of CA	EHB Tribal DHMO	E0005356 E0005360 E0005362 E0005364	SCFG00000286	\$0.00 (Adult) \$2.45 (Child 0-19)	Yes	Pre-Auth	EHB
Centene Health Net of CA	EHB DHMO	All other "E" Product ID's "E000XXXX"	SCFG00000284	\$0.00 (Adult) \$2.45 (Child 0-19)	Yes	Pre-Auth	EHB

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**HEALTH NET OF CA DHMO
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
EXHIBIT 2 - PART I**



CDT CODE	Agreement ID:	Minimum Guarantee	HN Value	HN Value	HN Value	HN Value	HN Value	HN Value	HN Value	HN Value
			DHMO 50	DHMO 85	DHMO 115	DHMO 150	DHMO 175	DHMO 225	DHMO 275	DHMO 115 (UC Post)
			SCFG00000189	SCFG00000190	SCFG00000191	SCFG00000192	SCFG00000193	SCFG00000194	SCFG00000195	SCFG00000221
PLAN TYPE:			Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial
MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
CDT codes not listed are not a covered benefit / NTCV = Not Covered										
I. DIAGNOSTIC										
D0120	periodic oral evaluation – established patient		0	0	0	0	0	0	0	0
D0140	limited oral evaluation – problem focused		0	0	0	0	0	0	0	0
D0150	comprehensive oral evaluation – new or established patient		0	0	0	0	0	0	0	0
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)		0	0	0	0	0	0	0	0
D0171	re-evaluation – post-operative office visit		0	0	0	0	0	0	0	0
D0180	comprehensive periodontal evaluation – new or established patient		0	0	0	0	0	0	0	0
D0190	screening of a patient		0	0	0	0	0	0	0	0
D0191	assessment of a patient		0	0	0	0	0	0	0	0
D0210	intraoral – complete series of radiographic images		0	0	0	0	0	0	0	0
D0220	intraoral – periapical first radiographic image		0	0	0	0	0	0	0	0
D0230	intraoral – periapical each additional radiographic image		0	0	0	0	0	0	0	0
D0240	intraoral – occlusal radiographic image		0	0	0	0	0	0	0	0
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector		0	0	0	0	0	0	0	0
D0251	extra-oral posterior dental radiographic image		0	0	0	0	0	0	0	0
D0270	bitewing – single radiographic image		0	0	0	0	0	0	0	0
D0272	bitewings – two radiographic images		0	0	0	0	0	0	0	0
D0274	bitewings – four radiographic images		0	0	0	0	0	0	0	0
D0277	vertical bitewings – 7 to 8 radiographic images		0	0	0	0	0	0	0	0
D0330	panoramic radiographic image		0	0	0	0	0	0	0	0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally		0	0	0	0	0	0	0	0
D0351	3D photographic image		0	0	0	0	0	0	0	0

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			SCFG00000189	SCFG00000190	SCFG00000191	SCFG00000192	SCFG00000193	SCFG00000194	SCFG00000195	SCFG00000221
	PLAN TYPE:		Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial
	MINIMUM GUARANTEE:		YES	YES	YES	YES	YES	YES	YES	YES*
	SPECIALTY REFERRAL:		PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report		0	0	0	0	0	0	0	0
D0411	HbA1c in-office point of service testing		0	0	0	0	0	0	0	0
D0417	collection and preparation of saliva sample for laboratory diagnostic testing		0	0	0	0	0	0	0	0
D0418	analysis of saliva sample		0	0	0	0	0	0	0	0
D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures		NTCV	NTCV	NTCV	NTCV	NTCV	NTCV	NTCV	20
D0460	pulp vitality tests		0	0	0	0	0	0	0	0
D0470	diagnostic casts		15	0	15	15	15	15	15	15
D0472	accession of tissue, gross examination, preparation and transmission of written report		0	0	0	0	0	0	0	0
D0473	accession of tissue, gross and microscopic examination, preparation and transmission of written report		0	0	0	0	0	0	0	0
D0474	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report		0	0	0	0	0	0	0	0
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum		0	0	0	0	0	0	0	0
D0601	caries risk assessment and documentation, with a finding of low risk		0	0	0	0	0	0	0	0
D0602	caries risk assessment and documentation, with a finding of moderate risk		0	0	0	0	0	0	0	0
D0603	caries risk assessment and documentation, with a finding of high risk		0	0	0	0	0	0	0	0

**HEALTH NET OF CA DHMO
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
EXHIBIT 2 - PART I**



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			SCFG00000189	SCFG00000190	SCFG00000191	SCFG00000192	SCFG00000193	SCFG00000194	SCFG00000195	SCFG00000221
PLAN TYPE:			Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial
MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
II. PREVENTIVE										
D1110	prophylaxis – adult (allowed once every six months)		0	0	0	0	0	0	0	0
D1110	prophylaxis – adult (In addition to one allowed every six months)		35	35	40	40	40	40	40	40
D1120	prophylaxis – child		0	0	0	0	0	0	0	0
D1120	prophylaxis – child (In addition to one allowed every six months)		25	25	25	25	25	25	25	25
D1208	topical application of fluoride – excluding varnish		0	0	0	0	0	0	0	0
D1310	nutritional counseling for control of dental disease		0	0	0	0	0	0	0	0
D1330	oral hygiene instructions		0	0	0	0	0	0	0	0
D1351	sealant – per tooth		5	5	5	8	10	12	15	5
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth		5	5	5	8	10	12	15	5
D1353	sealant repair – per tooth		5	5	5	8	10	12	15	5
D1354	interim caries arresting medicament application - per tooth		15	15	15	15	15	15	15	15
D1510	space maintainer – fixed, unilateral		20	20	20	35	45	55	65	20
D1516	space maintainer – fixed – bilateral, maxillary		20	20	20	35	45	55	65	20
D1517	space maintainer – fixed – bilateral, mandibular		20	20	20	35	45	55	65	20
D1520	space maintainer – removable – unilateral		20	20	20	35	45	55	65	20
D1526	space maintainer – removable – bilateral, maxillary		20	20	20	35	45	55	65	20
D1527	space maintainer – removable – bilateral, mandibular		20	20	20	35	45	55	65	20
D1550	re-cement or re-bond space maintainer		5	5	5	5	10	10	10	5
D1575	distal shoe space maintainer – fixed – unilateral		20	20	20	35	45	55	65	20

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EXHIBIT 2 - PART I**



CDT CODE	Agreement ID:	Minimum	HN Value	HN Value	HN Value	HN Value	HN Value	HN Value	HN Value	HN Value
		Guarantee	DHMO 50	DHMO 85	DHMO 115	DHMO 150	DHMO 175	DHMO 225	DHMO 275	DHMO 115 (UC Post)
		SCFG00000189	SCFG00000190	SCFG00000191	SCFG00000192	SCFG00000193	SCFG00000194	SCFG00000195	SCFG00000221	
	PLAN TYPE:		Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial
	MINIMUM GUARANTEE:		YES	YES	YES	YES	YES	YES	YES	YES*
	SPECIALTY REFERRAL:		PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH

III. RESTORATIVE

• Dental copayments have an additional charge not to exceed the actual lab cost for noble and high noble metals. In addition, porcelain on molar teeth is subject to an additional \$75 copayment.

** Copayments reflect primary versus permanent tooth copayment.

†† Materials upgrade for non-elective dental services (in addition to copayment for service).

D2140	amalgam – one surface, primary or permanent		0	0	0	0	8/14**	10/18**	12/20**	0
D2150	amalgam – two surfaces, primary or permanent		0	0	0	0	10/18**	12/20**	14/22**	0
D2160	amalgam – three surfaces, primary or permanent		0	0	0	0	15/20**	16/22**	20/24**	0
D2161	amalgam – four or more surfaces, primary or permanent		0	0	0	0	20/25**	24/27**	26/30**	0
D2330	resin-based composite – one surface, anterior		0	0	0	15	17	20	25	0
D2331	resin-based composite – two surfaces, anterior		0	0	0	20	22	24	28	0
D2332	resin-based composite – three surfaces, anterior		0	0	0	30	35	40	45	0
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		0	0	0	40	45	40	60	0
D2390	resin-based composite crown, anterior		30	30	30	40	45	50	60	30
D2391	resin-based composite – one surface, posterior		15	15	15	25	30	45	45	15/65**
D2392	resin-based composite – two surfaces, posterior		20	20	20	25	30	45	45	20/75**
D2393	resin-based composite – three surfaces, posterior		30	30	30	35	40	55	55	30/80**
D2394	resin-based composite – four or more surfaces, posterior		30	30	30	35	40	55	55	30/80**
D2510	inlay – metallic – one surface		50	85	115	150	175	225	275	115
D2520	inlay – metallic – two surfaces		50	85	115	150	175	225	275	115
D2530	inlay – metallic – three or more surfaces		50	85	115	150	175	225	275	115

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			SCFG00000189	SCFG00000190	SCFG00000191	SCFG00000192	SCFG00000193	SCFG00000194	SCFG00000195	SCFG00000221
PLAN TYPE:			Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial
MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D2542	onlay – metallic – two surfaces		50	85	115	150	175	225	275	115
D2543	onlay – metallic – three surfaces		50	85	115	150	175	225	275	115
D2544	onlay – metallic – four or more surfaces		50	85	115	150	175	225	275	115
D2740	crown – porcelain/ceramic	225	225	225	225	275	275	300	300	200
D2740	crown – porcelain/ceramic (Leucite-reinforced pressed crown/Empress manufacturer)		300 ⁺⁺	300 ⁺⁺	300 ⁺⁺	300 ⁺⁺	300 ⁺⁺	300 ⁺⁺	300 ⁺⁺	300 ⁺⁺
D2750	crown – porcelain fused to high noble metal		50	85	115	150	175	225	275	115
D2750	crown – porcelain fused to high noble metal (Gold composite reinforced crown/Captek manufacturer)		300 ⁺⁺	300 ⁺⁺	300 ⁺⁺	300 ⁺⁺	300 ⁺⁺	300 ⁺⁺	300 ⁺⁺	300 ⁺⁺
D2751	crown – porcelain fused to predominantly base metal		50	85	115	150	175	225	275	115
D2752	crown – porcelain fused to noble metal		50	85	115	150	175	225	275	115
D2780	crown – ¾ cast high noble metal		50	85	115	150	175	225	275	115
D2781	crown – ¾ cast predominantly base metal	130	50	85	115	150	175	225	275	115
D2782	crown – ¾ cast noble metal		50	85	115	150	175	225	275	115
D2783	crown – ¾ porcelain/ceramic		50	85	115	150	175	225	275	115
D2790	crown – full cast high noble metal	130	50	85	115	150	175	225	275	115
D2791	crown – full cast predominantly base metal	130	50	85	115	150	175	225	275	115
D2792	crown – full cast noble metal	130	50	85	115	150	175	225	275	115
D2794	crown – titanium	130	50	85	115	150	175	225	275	115
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		0	0	0	10	10	10	10	0
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		0	0	0	10	10	10	10	0
D2920	re-cement or re-bond crown		0	0	0	10	10	10	10	0
D2930	prefabricated stainless steel crown – primary tooth		0	0	0	15	25	25	45	0
D2931	prefabricated stainless steel crown – permanent tooth		0	0	0	15	35	35	45	0
D2940	protective restoration		0	0	0	0	0	0	0	0

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PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
EXHIBIT 2 - PART I**



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			SCFG00000189	SCFG00000190	SCFG00000191	SCFG00000192	SCFG00000193	SCFG00000194	SCFG00000195	SCFG00000221
PLAN TYPE:			Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial
MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D2941	interim therapeutic restoration – primary dentition		0	0	0	0	0	0	0	0
D2950	core buildup, including any pins when required		15	15	15	15	20	30	40	15
D2951	pin retention – per tooth, in addition to restoration		10	10	10	15	15	15	15	10
D2952	post and core in addition to crown, indirectly fabricated		25	25	25	50	60	75	80	25
D2953	each additional indirectly fabricated post – same tooth		25	25	25	25	30	40	50	25
D2954	prefabricated post and core in addition to crown		25	25	25	35	45	55	65	25
D2955	post removal		10	10	10	10	10	10	10	10
D2990	resin infiltration of incipient smooth surface lesions		5	5	5	8	10	12	15	5
IV. ENDODONTICS										
D3110	pulp cap – direct (excluding final restoration)		0	0	0	0	0	5	5	0
D3120	pulp cap – indirect (excluding final restoration)		0	0	0	0	0	5	5	0
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament		0	0	0	15	15	18	20	0
D3221	pulpal debridement, primary and permanent teeth		0	0	0	15	15	18	20	0
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development		0	0	0	15	15	18	20	NTCV
D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		5	5	5	10	20	25	30	5
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)		10	10	10	15	20	25	30	10

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MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D3310	endodontic therapy, anterior tooth (excluding final restoration)		70	70	70	75	80	85	90	70
D3320	endodontic therapy, premolar tooth (excluding final restoration)		80	80	80	100	120	145	160	80
D3330	endodontic therapy, molar tooth (excluding final restoration)	265	150	150	150	175	200	225	250	150
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		70	70	70	75	80	85	90	70
D3346	retreatment of previous root canal therapy – anterior		80	80	80	125	150	170	210	80
D3347	retreatment of previous root canal therapy – premolar		100	100	100	195	225	245	285	100
D3348	retreatment of previous root canal therapy – molar		160	160	200	225	260	275	300	200
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)		65	65	65	65	65	65	65	65
D3352	apexification/recalcification – interim medication replacement		65	65	65	65	65	65	65	65
D3353	apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)		65	65	65	65	65	65	65	65
D3355	Pulpal regeneration - initial visit		65	65	65	65	65	65	65	65
D3356	Pulpal regeneration -interim medicament replacement		65	65	65	65	65	65	65	65
D3357	Pulpal regeneration - completion of treatment		65	65	65	65	65	65	65	65
D3410	apicoectomy – anterior		90	90	90	115	115	125	150	90
D3421	apicoectomy – premolar (first root)		90	90	90	140	150	150	175	90
D3425	apicoectomy – molar (first root)		90	90	100	150	160	160	175	100
D3426	apicoectomy (each additional root)		90	90	90	100	125	125	125	90
D3427	periradicular surgery without apicoectomy		90	90	90	100	125	125	125	90

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MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D3430	retrograde filling – per root		90	90	90	95	95	95	95	90
D3450	root amputation – per root		95	95	95	100	125	150	175	95
D3920	hemisection (including any root removal), not including root canal therapy		90	90	90	90	100	125	150	90
V. PERIODONTICS - Includes periodontal charting for planning treatment of periodontal disease and periodontal hygiene instruction										
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant		35	35	35	50	75	100	125	35
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant		35	35	35	35	35	35	35	35
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant		150	150	150	200	250	275	275	150
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant		150	150	150	200	250	275	275	150
D4249	clinical crown lengthening – hard tissue		125	125	125	140	150	160	170	125
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant		250	250	275	300	325	350	400	275
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant		250	250	275	300	325	350	400	275
D4270	pedicle soft tissue graft procedure		250	250	300	325	375	375	425	300
D4273	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position		250	300	300	325	375	375	425	300

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MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)		50	50	50	50	50	50	50	50
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft		250	250	300	325	375	375	425	300
D4278	free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site		0	0	0	0	0	0	0	0
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site		250	300	300	325	375	375	425	300
D4341	periodontal scaling and root planing – four or more teeth per quadrant	25	15	15	25	30	35	40	50	25
D4342	periodontal scaling and root planing – one to three teeth per quadrant		15	15	25	30	35	40	50	25
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		15	15	15	25	30	35	40	15
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit		15	15	15	35	35	40	40	15
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth		60	60	60	60	60	60	60	60
D4910	periodontal maintenance		15	15	15	25	30	35	40	15
D4921	gingival irrigation - per quadrant		0	0	0	0	0	0	0	0

UHC will pay your office the difference between the Minimum Guarantee and the Member's Copayment.

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	MINIMUM GUARANTEE:		YES	YES	YES	YES	YES	YES	YES	YES*
	SPECIALTY REFERRAL:		PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
VI. PROSTHODONTICS (REMOVABLE) - Includes up to 3 adjustments within 6 months of delivery										
⁺⁺ Materials upgrade for non-elective dental services (in addition to copayment for service)										
D5110	complete denture – maxillary	110	100	100	125	150	175	200	250	125
D5110	complete denture - maxillary (Comfort Flex acetyl resin homopolymer)		400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺
D5120	complete denture – mandibular	110	100	100	125	150	175	200	250	125
D5120	complete denture - mandibular (Comfort Flex acetyl resin homopolymer)		400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺
D5130	immediate denture – maxillary		100	100	125	150	175	200	250	125
D5130	immediate denture - maxillary (Comfort Flex acetyl resin homopolymer)		400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺
D5140	immediate denture – mandibular		100	100	125	150	175	200	100	125
D5140	immediate denture - mandibular (Comfort Flex acetyl resin homopolymer)		400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺	400 ⁺⁺
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		100	100	150	175	200	225	250	150
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth) (Comfort Flex acetyl resin homopolymer)		425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		100	100	150	175	200	225	250	150
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth) (Comfort Flex acetyl resin homopolymer)		425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	120	100	125	175	200	225	250	275	175

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SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (Comfort Flex acetyl resin homopolymer)		425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	120	100	125	175	200	225	250	275	175
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (Comfort Flex acetyl resin homopolymer)		425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺	425 ⁺⁺
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		35	35	40	50	60	70	80	40
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		35	35	40	50	60	70	80	40
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		35	35	40	50	60	70	80	40
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		35	35	40	50	60	70	80	40
D5410	adjust complete denture – maxillary		0	0	10	10	10	15	15	10
D5411	adjust complete denture – mandibular		0	0	10	10	10	15	15	10
D5421	adjust partial denture – maxillary		0	0	10	10	10	15	15	10
D5422	adjust partial denture – mandibular		0	0	10	10	10	15	15	10

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MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D5511	repair broken complete denture base, mandibular		0	0	10	10	10	15	15	10
D5512	repair broken complete denture base, maxillary		0	0	10	10	10	15	15	10
D5611	repair resin partial denture base, mandibular		0	0	10	10	10	15	15	10
D5612	repair resin partial denture base, maxillary		0	0	10	10	10	15	15	10
D5621	repair cast partial framework, mandibular		0	0	10	10	10	15	15	10
D5622	repair cast partial framework, maxillary		0	0	10	10	10	15	15	10
D5630	repair or replace broken clasp – per tooth		10	10	15	15	25	30	40	15
D5640	replace broken teeth – per tooth		10	10	15	20	30	35	40	15
D5650	add tooth to existing partial denture		10	10	15	20	30	35	40	15
D5660	add clasp to existing partial denture – per tooth		10	10	15	15	25	35	45	15
D5710	rebase complete maxillary denture		35	35	50	50	75	100	125	50
D5711	rebase complete mandibular denture		35	35	50	50	75	100	125	50
D5720	rebase maxillary partial denture		35	35	50	50	75	100	125	50
D5721	rebase mandibular partial denture		20	35	50	50	75	100	125	50
D5730	reline complete maxillary denture (chairside)		20	20	25	25	40	45	50	25
D5731	reline complete mandibular denture (chairside)		20	20	25	25	40	45	50	25
D5740	reline maxillary partial denture (chairside)		20	20	25	25	40	45	50	25
D5741	reline mandibular partial denture (chairside)		20	20	25	25	40	45	50	25
D5750	reline complete maxillary denture (laboratory)		35	35	50	50	60	70	80	50
D5751	reline complete mandibular denture (laboratory)		35	35	50	50	60	70	80	50
D5760	reline maxillary partial denture (laboratory)		35	35	50	50	60	70	80	50
D5761	reline mandibular partial denture (laboratory)		35	35	50	50	60	70	80	50
D5810	interim complete denture (maxillary)		35	35	60	100	100	100	100	60
D5811	interim complete denture (mandibular)		35	35	60	100	100	100	100	60
D5820	interim partial denture (maxillary)		35	35	40	50	60	70	80	40
D5821	interim partial denture (mandibular)		35	35	40	50	60	70	80	40
D5850	tissue conditioning, maxillary		10	10	10	15	20	25	30	10

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SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D5851	tissue conditioning, mandibular		10	10	10	15	20	25	30	10
D5863	overdenture - complete maxillary		100	100	125	150	175	200	250	125
D5864	overdenture - complete mandibular		100	125	175	200	225	250	275	175
D5865	overdenture - partial maxillary		100	100	125	150	175	200	250	125
D5866	overdenture - partial mandibular		100	125	175	200	225	250	275	175
D5876	add metal substructure to acrylic full denture (per arch)		35	35	50	50	75	100	125	50

IX. PROSTHODONTICS, FIXED

• Dental copayments have an additional charge not to exceed the actual lab cost for noble and high noble metals. In addition, porcelain on molar teeth is subject to an additional \$75 copayment.

†† Materials upgrade for non-elective dental services (in addition to copayment for service)

D6210	pontic – cast high noble metal		50	85	115	150	175	225	275	115
D6211	pontic – cast predominantly base metal		50	85	115	150	175	225	275	115
D6212	pontic – cast noble metal		50	85	115	150	175	225	275	115
D6214	pontic – titanium		50	85	115	150	175	225	275	115
D6240	pontic – porcelain fused to high noble metal		50	85	115	150	175	225	275	115
D6240	pontic – porcelain fused to high noble metal (gold composite reinforced crown/Captek)		300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}
D6241	pontic – porcelain fused to high noble metal		50	85	115	150	175	225	275	115
D6242	pontic – porcelain fused to high noble metal		50	85	115	150	175	225	275	115
D6245	pontic – porcelain/ceramic		50	85	115	150	175	225	275	115
D6245	pontic – porcelain/ceramic (Leucite-reinforced pressed crown/Empress)		300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}
D6740	retainer crown – porcelain/ceramic	225	225	225	225	225	225	225	225	200
D6740	retainer crown – porcelain/ceramic		300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}
D6750	retainer crown – porcelain fused to high noble metal		50	85	115	150	175	225	275	115
D6750	retainer crown – porcelain fused to high noble metal (gold composite reinforced crown/Captek)		300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}	300 ^{††}
D6751	retainer crown – porcelain fused to predominantly base metal		50	85	115	150	175	225	275	115

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D6752	retainer crown – porcelain fused to noble metal		50	85	115	150	175	225	275	115
D6780	retainer crown – ¾ cast high noble metal		50	85	115	150	175	225	275	115
D6781	retainer crown – ¾ cast predominantly base metal		50	85	115	150	175	225	275	115
D6782	retainer crown – ¾ cast noble metal		50	85	115	150	175	225	275	115
D6790	retainer crown – full cast high noble metal		50	85	115	150	175	225	275	115
D6791	retainer crown – full cast predominantly base metal		50	85	115	150	175	225	275	115
D6792	retainer crown – full cast noble metal		50	85	115	150	175	225	275	115
D6794	retainer crown – titanium		50	85	115	150	175	225	275	115
D6930	re-cement or re-bond fixed partial denture		0	0	0	0	0	0	0	0
X. ORAL AND MAXILLOFACIAL SURGERY										
* Copayment for first extraction and each additional extraction.										
D7111	extraction, coronal remnants – primary tooth		0	0	0	8	10	15	20	0
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)		0	0	0	8/5*	10/8*	15/15*	15/17*	0
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		15	15	20	25	30	50	50	20
D7220	removal of impacted tooth – soft tissue		30	30	35	40	50	60	70	35
D7230	removal of impacted tooth – partially bony		60	60	65	70	75	80	85	65
D7240	removal of impacted tooth – completely bony		90	90	95	105	115	125	130	95
D7241	removal of impacted tooth – completely bony, with unusual surgical complications		130	130	130	130	130	150	160	130
D7250	removal of residual tooth roots (cutting procedure)		50	50	50	50	50	50	50	50
D7251	coronectomy – intentional partial tooth removal		50	50	50	50	50	50	50	50
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth		110	110	110	110	110	110	110	110
D7280	exposure of an unerupted tooth		175	175	175	175	175	175	175	175

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			DHMO 50	DHMO 85	DHMO 115	DHMO 150	DHMO 175	DHMO 225	DHMO 275	DHMO 115 (UC Post)
			SCFG00000189	SCFG00000190	SCFG00000191	SCFG00000192	SCFG00000193	SCFG00000194	SCFG00000195	SCFG00000221
PLAN TYPE:			Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial
MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D7285	incisional biopsy of oral tissue – hard (bone, tooth)		0	0	15	40	50	60	70	15
D7286	incisional biopsy of oral tissue – soft		0	0	25	50	50	60	70	25
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		0	0	20	30	45	55	65	20
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		0	0	7	10	15	18	33	7
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		0	0	40	50	60	75	80	40
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		0	0	14	17	30	25	27	14
D7510	incision and drainage of abscess – intraoral soft tissue		0	0	0	0	0	0	0	0
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		0	0	0	0	0	0	0	0
D7881	occlusal orthotic device adjustment		0	0	10	10	10	15	15	10
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure		0	0	10	25	35	45	55	10
D7963	frenuloplasty		0	0	10	25	35	45	55	10
D7971	excision of pericoronal gingiva		40	40	40	40	50	60	70	40
X. ADJUNCTIVE GENERAL SERVICES										
D9110	palliative (emergency) treatment of dental pain – minor procedure		0	0	20	20	20	20	20	0
D9210	local anesthesia not in conjunction with operative or surgical procedures		0	0	0	0	0	0	0	0
D9211	regional block anesthesia		0	0	0	0	0	0	0	0

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			SCFG00000189	SCFG00000190	SCFG00000191	SCFG00000192	SCFG00000193	SCFG00000194	SCFG00000195	SCFG00000221
PLAN TYPE:			Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial
MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D9215	local anesthesia in conjunction with operative or surgical procedures		0	0	0	0	0	0	0	0
D9219	evaluation for deep sedation or general anesthesia		0	0	0	0	0	0	0	0
D9222	deep sedation/general anesthesia – first 15 minutes		60	60	60	60	60	60	60	60
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment		60	60	60	60	60	60	60	60
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes		60	60	60	60	60	60	60	60
D9243	intravenous moderate (conscious) sedation/anesthesia – each subsequent 15 minute increment		60	60	60	60	60	60	60	60
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		0	0	0	0	0	0	0	0
D9311	consultation with a medical health care professional		0	0	0	0	0	0	0	0
D9430	office visit for observation (during regularly scheduled hours) – no other services performed		0	0	0	0	0	0	0	0
D9440	office visit – after regularly scheduled hours		20	20	20	20	20	20	20	20
D9630	drugs or medicaments dispensed in the office for home use		15	15	15	15	15	15	15	15
D9910	application of desensitizing medicament		15	15	15	15	15	15	15	15
D9942	repair and/or relines of occlusal guard		35	35	50	50	40	70	80	50
D9943	occlusal guard adjustment		0	0	10	10	10	15	15	10
D9944	occlusal guard – hard appliance, full arch		100	100	100	100	100	100	100	100
D9945	occlusal guard – soft appliance, full arch		100	100	100	100	100	100	100	100
D9946	occlusal guard – hard appliance, partial arch		50	50	50	50	50	50	50	50
D9951	occlusal adjustment – limited		0	0	0	0	0	0	0	0
D9952	occlusal adjustment – complete		0	0	0	75	75	75	75	0

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PLAN TYPE:			Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial
MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D9972	external bleaching – per arch – performed in office		125	125	125	125	125	125	125	125
D9995	teledentistry – synchronous; real-time encounter		0	0	0	0	0	0	0	0
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review		0	0	0	0	0	0	0	0
D9999	record transfer - transfer of all materials with or without an x-ray(s)		0	0	15	15	15	17	15	15
XI. COSMETIC DENTISTRY SERVICES (ELECTIVE SERVICES)										
D2330	resin-based composite – one surface, anterior		80	80	80	80	80	80	80	80
D2331	resin-based composite – two surfaces, anterior		95	95	95	95	95	95	95	95
D2332	resin-based composite – three surfaces, anterior		105	105	105	105	105	105	105	105
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		125	125	125	125	125	125	125	125
D2391	resin-based composite – one surface, posterior		85	85	85	85	85	85	85	85
D2392	resin-based composite – two surfaces, posterior		100	100	100	100	100	100	100	100
D2393	resin-based composite – three surfaces, posterior		110	110	110	110	110	110	110	110
D2394	resin-based composite – four or more surfaces, posterior		130	130	130	130	130	130	130	130
D2740	crown – porcelain/ceramic		700	700	700	700	700	700	700	700
D2750	crown – porcelain fused to high noble metal		500	500	500	500	500	500	500	500
D2751	crown – porcelain fused to predominantly base metal		500	500	500	500	500	500	500	500
D2752	crown – porcelain fused to noble metal		500	500	500	500	500	500	500	500
D2962	labial veneer (porcelain laminate) – laboratory		450	450	450	450	450	450	450	450

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PLAN TYPE:			Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial	Commercial
MINIMUM GUARANTEE:			YES	YES	YES	YES	YES	YES	YES	YES*
SPECIALTY REFERRAL:			PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH	PRE-AUTH
D2983	veneer repair necessitated by restorative material failure		450	450	450	450	450	450	450	450
D5110	complete denture – maxillary (Comfort Flex acetyl resin homopolymer)		650	650	650	650	650	650	650	650
D5120	complete denture – mandibular (Comfort Flex acetyl resin homopolymer)		650	650	650	650	650	650	650	650
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth) - (Comfort Flex acetyl resin homopolymer)		725	725	725	725	725	725	725	725
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth) - (Comfort Flex acetyl resin homopolymer)		725	725	725	725	725	725	725	725
D9972	external bleaching – per arch – performed in office		125	125	125	125	125	125	125	125
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays		125	125	125	125	125	125	125	125
D9999	Record transfer - transfer of all materials with or without an x-ray(s)		0	0	15	15	15	15	15	15

MINIMUM GUARANTEE NOTES:

1 Reimbursement for only two (2) quadrants per visit. A maximum of four (4) quadrants will be paid in any combination per calendar year. A copy of periodontal charting is required for reimbursement. Additional documentation may be required on a case by case basis.

- Submit the minimum guarantee reimbursement for crowns, abutment crowns, pontics, inlays, and onlays at final insertion / completion of the procedure.

Minimum Guarantee	\$185
Member Copayment to your office	\$85
Plan Pays your office upon receipt of claim	<u>\$100</u>

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.

EXHIBIT 2

**HN VALUE DHMO 50 - VALUE DHMO 275,
HN Value DHMO 115 (UC Post)
LIMITATION OF BENEFITS**

Listed below are limitations on services covered under the plan.

1. Frequency – The frequency of certain benefits is limited. The Schedule of Benefits and Member Copayment Schedule lists any limitations on frequency.
2. Specialty Care – Payment authorization is required for coverage of services by a participating Network Specialist.
3. Oral Surgery – The surgical removal of an impacted wisdom tooth is not covered if there is no pathology present, or if the removal is for orthodontic reasons.
4. Replacement of an existing crown (non-elective service) is covered only if it cannot be repaired and restored to natural function.
5. Replacement of an existing full or removable denture (non-elective service) is covered only if it is unsatisfactory and cannot be made satisfactory by either reline or repair.
6. Palliative treatment of dental pain will be considered for payment as a separate benefit only if no other services are rendered during visit.
7. Notwithstanding anything to the contrary that may be contained in the Evidence of Coverage, you will be reimbursed for all covered services which are deemed necessary emergency dental care.

EXCLUSION OF BENEFITS

Listed below are those services or expenses NOT covered under the plan that become the responsibility of the member at the dentist's Usual and Customary fee.

1. Services not listed on the Schedule of Benefits or Principal Benefits and Coverages - Member Copayment Schedule.
2. Services provided by a non-participating provider without prior approval, except in emergencies.
3. Services related to any injury or illness covered under Workers' Compensation, occupational disease or similar laws.
4. Services provided or paid through a federal or state government agency or authority, political subdivision or public program other than Medicaid.
5. Services relating to injuries which are intentionally self-inflicted. **(Not applicable to HN Assoc DHMO plan)**
6. Services required while serving in the armed forces of any country or international authority or relating to a declared authority or undeclared act of war.
7. Cosmetic dentistry unless specifically listed as a covered benefit.
8. Prescription drugs.
9. Procedures, appliances or restorations if the purpose is to, a) change vertical dimension, or b) diagnose or treat abnormal conditions of the temporomandibular joint.
10. The completion of crown and bridge, dentures, root canal treatment, and orthodontics already in progress on the date the member becomes eligible under the plan.
11. Services associated with the placement or prosthodontic restoration of a dental implant.
12. Services considered to be unnecessary or experimental in nature.
13. Procedures or appliances for minor tooth guidance or to control harmful habits.
14. Hospitalization, including any associated incremental charges for dental services performed in a hospital.
15. Services to the extent the member is compensated for them under any group medical plan, no fault insurance policy or insured.
16. Crowns and bridges used solely for splinting.
17. Resin bonded retainers and associated pontics.

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CDT CODE	Plan Name: Agreement ID:	Minimum Guarantee	HN Plus DHMO 85	HN Plus DHMO 100	HN Plus DHMO 150	HN Plus DHMO 185	HN Plus DHMO 225	HN FB DHMO Preferred
			SCFG00000196	SCFG00000197	SCFG00000198	SCFG00000199	SCFG00000200	SCFG00000202
	PLAN TYPE:		Commercial	Commercial	Commercial	Commercial	Commercial	Commercial
	MINIMUM GUARANTEE:		YES	YES	YES	YES	YES	YES
	SPECIALTY REFERRAL:		DIRECT	DIRECT	DIRECT	DIRECT	DIRECT	SELF
These plans provide for any Non-Covered service to be offered at 75% of Dentist UCR / NTCV = Not Covered								
I. DIAGNOSTIC								
D0120	periodic oral evaluation – established patient		0	0	0	0	0	0
D0140	limited oral evaluation – problem focused		0	0	0	0	0	5
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver		0	0	0	0	0	0
D0150	comprehensive oral evaluation – new or established patient		0	0	0	0	0	0
D0160	detailed and extensive oral evaluation – problem focused, by report		0	0	0	0	0	0
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)		0	0	0	0	0	0
D0171	re-evaluation – post-operative office visit		0	0	0	0	0	5
D0180	comprehensive periodontal evaluation – new or established patient		0	0	0	0	0	0
D0190	screening of a patient		0	0	0	0	0	5
D0191	assessment of a patient		0	0	0	0	0	5
D0210	intraoral – complete series of radiographic images		0	0	0	0	0	0
D0220	intraoral – periapical first radiographic image		0	0	0	0	0	0
D0230	intraoral – periapical each additional radiographic image		0	0	0	0	0	0
D0240	intraoral – occlusal radiographic image		0	0	0	0	0	0
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector		0	0	0	0	0	0
D0251	extra-oral posterior dental radiographic image		0	0	0	0	0	0
D0270	bitewing – single radiographic image		0	0	0	0	0	0
D0272	bitewings – two radiographic images		0	0	0	0	0	0
D0273	bitewings – three radiographic images		0	0	0	0	0	0
D0274	bitewings – four radiographic images		0	0	0	0	0	0
D0277	vertical bitewings – 7 to 8 radiographic images		0	0	0	0	0	0
D0330	panoramic radiographic image		0	0	0	0	0	0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally		0	0	0	0	0	0
D0351	3D photographic image		0	0	0	0	0	0
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report		0	0	0	0	0	0
D0411	HbA1c in-office point of service testing		0	0	0	0	0	0
D0412	blood glucose level test – in-office using a glucose meter		0	0	0	0	0	0

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D0414	laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report		0	0	0	0	0	0
D0415	collection of microorganisms for culture and sensitivity		0	0	0	0	0	0
D0417	collection and preparation of saliva sample for laboratory diagnostic testing		0	0	0	0	0	0
D0418	analysis of saliva sample		0	0	0	0	0	0
D0422	collection and preparation of genetic sample material for laboratory analysis and report		0	0	0	0	0	0
D0423	genetic test for susceptibility to diseases – specimen analysis		0	0	0	0	0	0
D0425	caries susceptibility tests	3	0	0	0	0	0	0
D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures		50	50	50	50	50	50
D0460	pulp vitality tests		0	0	0	0	0	0
D0470	diagnostic casts		0	0	0	0	0	0
D0472	accession of tissue, gross examination, preparation and transmission of written report		0	0	0	0	0	NTCV
D0473	accession of tissue, gross and microscopic examination, preparation and transmission of written report		0	0	0	0	0	NTCV
D0474	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report		0	0	0	0	0	NTCV
D0486	laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.		0	0	0	0	0	NTCV
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum		0	0	0	0	0	0
D0601	caries risk assessment and documentation, with a finding of low risk		0	0	0	0	0	0
D0602	caries risk assessment and documentation, with a finding of moderate risk		0	0	0	0	0	0
D0603	caries risk assessment and documentation, with a finding of high risk		0	0	0	0	0	0
D0999	office visit fee - per visit (\$2 Minimum Guarantee applies to HN FB DHMO Preferred plan)	4 / 2	0	0	0	0	0	0
II. PREVENTIVE								
D1110	prophylaxis – adult	3	0	0	0	0	0	0
D1110	additional - adult prophylaxis (maximum of 2 additional per year)		20	20	20	35	35	35
D1120	prophylaxis – child	3	0	0	0	0	0	0
D1120	additional - child prophylaxis (maximum of 2 additional per year)		15	15	15	25	25	25

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D1206	topical application of fluoride varnish		0	0	0	0	0	0
D1208	topical application of fluoride – excluding varnish		0	0	0	0	0	0
D1310	nutritional counseling for control of dental disease		0	0	0	0	0	0
D1320	tobacco counseling for the control and prevention of oral disease		0	0	0	0	0	0
D1330	oral hygiene instructions		0	0	0	0	0	0
D1351	sealant – per tooth	5	0	0	0	0	0	5
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth		0	0	0	0	0	5
D1353	sealant repair – per tooth		0	0	0	0	0	5
D1354	interim caries arresting medicament application - per tooth		15	15	15	15	15	NTCV
D1510	space maintainer – fixed, unilateral	20	0	0	25	25	25	65
D1516	space maintainer – fixed – bilateral, maxillary	20	0	0	25	25	25	65
D1517	space maintainer – fixed – bilateral, mandibular	20	0	0	25	25	25	65
D1520	space maintainer – removable – unilateral		0	0	35	35	35	80
D1526	space maintainer – removable – bilateral, maxillary		0	0	35	35	35	80
D1527	space maintainer – removable – bilateral, mandibular		0	0	35	35	35	80
D1550	re-cement or re-bond space maintainer		5	5	5	5	15	15
D1555	removal of fixed space maintainer		5	5	5	5	15	15
D1575	distal shoe space maintainer – fixed – unilateral		0	0	25	25	25	65
III. RESTORATIVE								
<ul style="list-style-type: none"> • An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a \$75 copayment per crown/bridge unit in addition to regular copayments for porcelain on molars. • Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional \$125 copayment per unit in addition to copayment for each crown/bridge unit. 								
D2140	amalgam – one surface, primary or permanent		0	0	0	0	0	0
D2150	amalgam – two surfaces, primary or permanent		0	0	0	0	0	0
D2160	amalgam – three surfaces, primary or permanent		0	0	0	0	0	0
D2161	amalgam – four or more surfaces, primary or permanent		0	0	0	0	0	0
D2330	resin-based composite – one surface, anterior		0	0	0	0	0	25
D2331	resin-based composite – two surfaces, anterior		0	0	0	0	0	35
D2332	resin-based composite – three surfaces, anterior		0	0	0	0	0	50
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		0	0	0	0	0	70
D2390	resin-based composite crown, anterior	35	20	20	20	30	30	60
D2391	resin-based composite – one surface, posterior	65	25	25	25	30	30	65
D2392	resin-based composite – two surfaces, posterior	75	30	30	30	45	45	75
D2393	resin-based composite – three surfaces, posterior	80	35	35	35	65	65	85

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D2394	resin-based composite – four or more surfaces, posterior	80	40	40	40	65	65	85
D2510	inlay – metallic – one surface		85	100	125	165	185	225
D2520	inlay – metallic – two surfaces		85	100	125	165	185	235
D2530	inlay – metallic – three or more surfaces		85	100	125	165	185	245
D2542	onlay – metallic – two surfaces		85	100	150	185	225	NTCV
D2543	onlay – metallic – three surfaces		85	100	150	185	225	260
D2544	onlay – metallic – four or more surfaces		85	100	150	185	225	300
D2610	inlay – porcelain/ceramic – one surface	185	85	100	150	185	225	245
D2620	inlay – porcelain/ceramic – two surfaces	185	85	100	150	185	225	245
D2630	inlay – porcelain/ceramic – three or more surfaces	185	85	100	150	185	225	245
D2642	onlay – porcelain/ceramic – two surfaces	185	85	100	150	185	225	NTCV
D2643	onlay – porcelain/ceramic – three surfaces	185	85	100	150	185	225	NTCV
D2644	onlay – porcelain/ceramic – four or more surfaces	185	85	100	150	185	225	NTCV
D2650	inlay – resin-based composite – one surface	185	85	100	150	185	225	NTCV
D2651	inlay – resin-based composite – two surfaces	185	85	100	150	185	225	NTCV
D2652	inlay – resin-based composite – three or more surfaces	185	85	100	150	185	225	NTCV
D2662	onlay – resin-based composite – two surfaces	185	85	100	150	185	225	NTCV
D2663	onlay – resin-based composite – three surfaces	185	85	100	150	185	225	NTCV
D2664	onlay – resin-based composite – four or more surfaces	185	85	100	150	185	225	NTCV
D2710	crown – resin-based composite (indirect)	185	85	100	150	185	225	NTCV
D2712	crown – ¾ resin-based composite (indirect)	185	85	100	150	185	225	NTCV
D2720	crown – resin with high noble metal	185	85	100	150	185	225	NTCV
D2721	crown – resin with predominantly base metal	185	85	100	150	185	225	NTCV
D2722	crown – resin with noble metal	185	85	100	150	185	225	NTCV
D2740	crown – porcelain/ceramic	185	225	225	225	225	225	245
D2750	crown – porcelain fused to high noble metal	185	85	100	150	185	225	245
D2751	crown – porcelain fused to predominantly base metal	185	85	100	150	185	225	245
D2752	crown – porcelain fused to noble metal	185	85	100	150	185	225	245
D2780	crown – ¾ cast high noble metal	185	85	100	150	185	225	245
D2781	crown – ¾ cast predominantly base metal	185	85	100	150	185	225	245
D2782	crown – ¾ cast noble metal	185	85	100	150	185	225	245
D2783	crown – ¾ porcelain/ceramic	185	85	100	150	185	225	NTCV
D2790	crown – full cast high noble metal	185	85	100	150	185	225	245
D2791	crown – full cast predominantly base metal	185	85	100	150	185	225	245
D2792	crown – full cast noble metal	185	85	100	150	185	225	245
D2794	crown – titanium		85	100	150	185	225	245

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D2799	provisional crown– further treatment or completion of diagnosis necessary prior to final impression		0	0	0	0	0	0
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		0	0	0	0	0	15
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		0	0	0	0	0	15
D2920	re-cement or re-bond crown		0	0	0	0	0	15
D2921	reattachment of tooth fragment, incisal edge or cusp		0	0	0	0	0	0
D2930	prefabricated stainless steel crown – primary tooth		0	0	25	25	25	40
D2931	prefabricated stainless steel crown – permanent tooth		0	0	25	25	25	40
D2932	prefabricated resin crown		0	0	35	35	45	NTCV
D2933	prefabricated stainless steel crown with resin window		0	0	35	35	45	NTCV
D2940	protective restoration		0	0	0	0	0	10
D2941	interim therapeutic restoration – primary dentition		0	0	0	0	0	10
D2950	core buildup, including any pins when required		15	15	15	15	70	70
D2951	pin retention – per tooth, in addition to restoration		10	10	10	10	10	15
D2952	post and core in addition to crown, indirectly fabricated		25	40	50	50	50	85
D2953	each additional indirectly fabricated post – same tooth		25	40	50	50	50	NTCV
D2954	prefabricated post and core in addition to crown		25	40	30	30	30	75
D2955	post removal		10	10	10	10	10	40
D2957	each additional prefabricated post – same tooth		25	25	30	30	30	NTCV
D2960	labial veneer (resin laminate) – chairside		250	250	250	250	250	300
D2961	labial veneer (resin laminate) – laboratory		300	300	300	300	300	380
D2962	labial veneer (porcelain laminate) – laboratory		350	350	350	350	350	380
D2971	additional procedures to construct new crown under existing partial denture framework		50	50	50	50	50	NTCV
D2980	crown repair necessitated by restorative material failure		0	0	0	0	0	0
D2981	inlay repair necessitated by restorative material failure		0	0	0	0	0	0
D2982	onlay repair necessitated by restorative material failure		0	0	0	0	0	0
D2983	veneer repair necessitated by restorative material failure		0	0	0	0	0	0
D2990	resin infiltration of incipient smooth surface lesions		0	0	0	0	0	5
IV. ENDODONTICS								
D3110	pulp cap – direct (excluding final restoration)		0	0	0	0	0	10
D3120	pulp cap – indirect (excluding final restoration)		0	0	0	0	0	10
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament		0	0	0	10	30	30
D3221	pulpal debridement, primary and permanent teeth		20	20	20	45	55	55
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development		0	0	0	10	30	30

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D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		5	5	5	30	40	40
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)		10	10	10	35	40	40
D3310	endodontic therapy, anterior tooth (excluding final restoration)	70	40	40	58	80	80	110
D3320	endodontic therapy, premolar tooth (excluding final restoration)	80	65	65	95	115	125	185
D3330	endodontic therapy, molar tooth (excluding final restoration)	265	95	95	125	200	210	265
D3331	treatment of root canal obstruction; non-surgical access		45	55	75	85	85	NTCV
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	70	40	50	63	70	70	110
D3333	internal root repair of perforation defects		45	55	75	85	85	NTCV
D3346	retreatment of previous root canal therapy – anterior	80	65	65	80	135	135	180
D3347	retreatment of previous root canal therapy – premolar	100	90	90	125	175	175	280
D3348	retreatment of previous root canal therapy – molar	160	160	160	215	275	275	325
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)		65	65	65	65	70	90
D3352	apexification/recalcification – interim medication replacement		65	65	65	65	70	90
D3353	apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)		65	65	65	65	70	90
D3355	Pulpal regeneration - initial visit		65	65	65	65	70	90
D3356	Pulpal regeneration -interim medicament replacement		65	65	65	65	70	90
D3357	Pulpal regeneration - completion of treatment		65	65	65	65	70	90
D3410	apicoectomy – anterior		90	95	95	95	95	100
D3421	apicoectomy – premolar (first root)		90	95	95	95	95	100
D3425	apicoectomy – molar (first root)		90	95	95	95	95	100
D3426	apicoectomy (each additional root)		60	60	60	60	60	60
D3427	periradicular surgery without apicoectomy		60	60	60	60	60	60
D3430	retrograde filling – per root		10	10	10	40	40	60
D3450	root amputation – per root		95	95	95	95	95	95
D3910	surgical procedure for isolation of tooth with rubber dam		19	19	19	19	19	NTCV
D3920	hemisection (including any root removal), not including root canal therapy		90	90	90	90	90	90
D3950	canal preparation and fitting of preformed dowel or post		15	15	15	15	15	NTCV
V. PERIODONTICS - Includes periodontal charting for planning treatment of periodontal disease and periodontal hygiene instruction								
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant		35	50	55	90	110	110

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D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant		26	38	40	68	83	83
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth		9	13	13	22	27	27
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant		100	100	100	150	150	150
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant		78	78	78	113	113	113
D4245	apically positioned flap		115	165	165	165	165	NTCV
D4249	clinical crown lengthening – hard tissue	125	120	120	120	120	120	150
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant		160	260	260	295	295	300
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant		123	198	198	210	210	225
D4263	bone replacement graft – retained natural tooth – first site in quadrant		135	180	180	180	180	NTCV
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant		95	95	95	95	95	NTCV
D4265	biologic materials to aid in soft and osseous tissue regeneration		95	95	95	95	95	NTCV
D4266	guided tissue regeneration – resorbable barrier, per site		215	215	215	215	215	NTCV
D4267	guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal)		255	255	255	255	255	NTCV
D4270	pedicle soft tissue graft procedure		85	195	195	245	245	245
D4273	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position		75	75	75	75	75	75
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)		50	70	70	70	70	100
D4275	non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft		125	265	265	380	380	NTCV
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft		120	195	195	245	245	245
D4278	free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site		0	0	0	0	0	NTCV
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site		75	75	75	75	75	75

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D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site		125	265	265	380	380	NTCV
D4320	provisional splinting – intracoronal		85	85	85	95	95	95
D4321	provisional splinting – extracoronal		75	75	75	85	85	95
D4341	periodontal scaling and root planing – four or more teeth per quadrant	50 ¹	15	25	35	40	40	50
D4342	periodontal scaling and root planing – one to three teeth per quadrant		11	19	26	30	30	38
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		15	15	30	30	30	40
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit		15	15	35	40	40	50
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth		60	60	60	60	60	65
D4910	periodontal maintenance		15	15	30	30	30	40
D4910	additional periodontal maintenance procedures - beyond 2 per 12 months		40	40	55	55	55	55
D4921	gingival irrigation - per quadrant		0	0	0	0	0	0
VI. PROSTHODONTICS (REMOVABLE) - Includes up to 3 adjustments within 6 months of delivery								
D5110	complete denture – maxillary	210	100	125	175	210	260	325
D5120	complete denture – mandibular	210	100	125	175	210	260	325
D5130	immediate denture – maxillary	210	100	125	175	225	240	350
D5140	immediate denture – mandibular	250	100	125	175	225	240	350
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		100	110	150	240	240	400
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		100	110	150	240	240	400
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	250	125	150	200	260	260	425
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	250	125	150	200	260	260	425
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		35	40	50	60	60	175
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		35	40	50	60	60	175
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		35	40	50	60	60	175

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D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		35	40	50	60	60	175
D5225	maxillary partial denture – flexible base (including any clasps, rests and teeth)	250	365	365	365	365	365	NTCV
D5226	mandibular partial denture – flexible base (including any clasps, rests and teeth)	250	365	365	365	365	365	NTCV
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	250	125	150	200	250	250	NTCV
D5283	removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	250	125	150	200	250	250	NTCV
D5410	adjust complete denture – maxillary		0	0	0	0	10	10
D5411	adjust complete denture – mandibular		0	0	0	0	10	10
D5421	adjust partial denture – maxillary		0	0	0	0	10	10
D5422	adjust partial denture – mandibular		0	0	0	0	10	10
D5511	repair broken complete denture base, mandibular		0	0	0	0	10	10
D5512	repair broken complete denture base, maxillary		0	0	0	0	10	10
D5611	repair resin partial denture base, mandibular		0	0	0	0	10	10
D5612	repair resin partial denture base, maxillary		0	0	0	0	10	10
D5621	repair cast partial framework, mandibular		0	0	0	0	10	10
D5622	repair cast partial framework, maxillary		0	0	0	0	10	10
D5630	repair or replace broken clasp – per tooth		10	15	25	35	35	35
D5640	replace broken teeth – per tooth		10	15	25	30	30	35
D5650	add tooth to existing partial denture		10	15	25	30	30	35
D5660	add clasp to existing partial denture – per tooth		10	15	25	35	35	35
D5670	replace all teeth and acrylic on cast metal framework (maxillary)		165	165	165	165	165	NTCV
D5671	replace all teeth and acrylic on cast metal framework (mandibular)		165	165	165	165	165	NTCV
D5710	rebase complete maxillary denture		35	50	60	60	60	75
D5711	rebase complete mandibular denture		35	50	60	60	60	75
D5720	rebase maxillary partial denture		35	50	60	60	60	75
D5721	rebase mandibular partial denture		35	50	60	60	60	75
D5730	reline complete maxillary denture (chairside)		20	35	35	35	35	65
D5731	reline complete mandibular denture (chairside)		20	35	35	35	35	65
D5740	reline maxillary partial denture (chairside)		20	35	35	35	35	65
D5741	reline mandibular partial denture (chairside)		20	35	35	35	35	65
D5750	reline complete maxillary denture (laboratory)		35	40	50	60	60	85
D5751	reline complete mandibular denture (laboratory)		35	40	50	60	60	85
D5760	reline maxillary partial denture (laboratory)		35	40	50	60	60	85

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D5761	reline mandibular partial denture (laboratory)		35	40	50	60	60	85
D5810	interim complete denture (maxillary)		100	130	180	230	230	NTCV
D5811	interim complete denture (mandibular)		100	130	180	230	230	NTCV
D5820	interim partial denture (maxillary)		35	40	50	60	60	175
D5821	interim partial denture (mandibular)		35	40	50	60	60	175
D5850	tissue conditioning, maxillary		10	10	10	10	20	20
D5851	tissue conditioning, mandibular		10	10	10	10	20	20
D5863	overdenture - complete maxillary		100	125	175	210	260	325
D5864	overdenture - complete mandibular		125	150	200	260	260	425
D5865	overdenture - partial maxillary		100	125	175	210	260	325
D5866	overdenture - partial mandibular		125	150	200	260	260	425
D5862	precision attachment, by report		160	160	160	160	160	NTCV
D5876	add metal substructure to acrylic full denture (per arch)		35	50	60	60	60	75
VIII. IMPLANT SERVICES								
D6010	surgical placement of implant body: endosteal implant		1,950	1,950	1,950	1,950	1,950	NTCV
D6013	surgical placement of a mini-implant		1,950	1,950	1,950	1,950	1,950	NTCV
D6052	semi-precision attachment abutment		368	368	368	368	368	NTCV
D6055	connecting bar – implant supported or abutment supported		540	540	540	540	540	NTCV
D6056	prefabricated abutment – includes modification and placement		368	368	368	368	368	NTCV
D6057	custom fabricated abutment – includes placement		610	610	610	610	610	NTCV
D6058	abutment supported porcelain/ceramic crown		1,050	1,050	1,050	1,050	1,050	NTCV
D6059	abutment supported porcelain fused to metal crown (high noble metal)		915	915	915	915	915	NTCV
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)		1,050	1,050	1,050	1,050	1,050	NTCV
D6061	abutment supported porcelain fused to metal crown (noble metal)		946	946	946	946	946	NTCV
D6062	abutment supported cast metal crown (high noble metal)		981	981	981	981	981	NTCV
D6063	abutment supported cast metal crown (predominantly base metal)		854	854	854	854	854	NTCV
D6064	abutment supported cast metal crown (noble metal)		1,168	1,168	1,168	1,168	1,168	NTCV
D6065	implant supported porcelain/ceramic crown		1,144	1,144	1,144	1,144	1,144	NTCV
D6066	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)		1,083	1,083	1,083	1,083	1,083	NTCV
D6067	implant supported metal crown (titanium, titanium alloy, high noble metal)		962	962	962	962	962	NTCV
D6068	abutment supported retainer for porcelain/ceramic FPD		1,026	1,026	1,026	1,026	1,026	NTCV
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)		1,050	1,050	1,050	1,050	1,050	NTCV

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D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)		965	965	965	965	965	NTCV
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)		984	984	984	984	984	NTCV
D6072	abutment supported retainer for cast metal FPD (high noble metal)		997	997	997	997	997	NTCV
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)		910	910	910	910	910	NTCV
D6074	abutment supported retainer for cast metal FPD (noble metal)		967	967	967	967	967	NTCV
D6075	implant supported retainer for ceramic FPD		1,018	1,018	1,018	1,018	1,018	NTCV
D6076	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)		992	992	992	992	992	NTCV
D6077	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)		962	962	962	962	962	NTCV
D6080	implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments		55	55	55	55	55	NTCV
D6085	provisional implant crown		0	0	0	0	0	0
D6090	repair implant supported prosthesis, by report		135	135	135	135	135	NTCV
D6091	replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment		410	410	410	410	410	NTCV
D6092	re-cement or re-bond implant/abutment supported crown		79	79	79	79	79	NTCV
D6093	re-cement or re-bond implant/abutment supported fixed partial denture		124	124	124	124	124	NTCV
D6094	abutment supported crown (titanium)		810	810	810	810	810	NTCV
D6095	repair implant abutment, by report		55	55	55	55	55	NTCV
D6100	implant removal, by report		600	600	600	600	600	NTCV
D6101	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure		57	57	57	57	57	NTCV
D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure		190	190	190	190	190	NTCV
D6103	bone graft for repair of peri-implant defect – does not include flap entry and closure		350	350	350	350	350	NTCV
D6110	implant /abutment supported removable denture for edentulous arch – maxillary		925	925	925	925	925	NTCV
D6111	implant /abutment supported removable denture for edentulous arch – mandibular		925	925	925	925	925	NTCV

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D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary		925	925	925	925	925	NTCV
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular		925	925	925	925	925	NTCV
D6190	radiographic/surgical implant index, by report		265	265	265	265	265	NTCV
D6194	abutment supported retainer crown for FPD – (titanium)		835	835	835	835	835	NTCV
VII. MAXILLOFACIAL PROSTHETICS								
<ul style="list-style-type: none"> • An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a \$75 copayment per crown/bridge unit in addition to regular copayments for porcelain on molars. • Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional \$125 copayment per unit in addition to copayment for each crown/bridge unit. 								
D6210	pontic – cast high noble metal	185	85	100	150	185	225	245
D6211	pontic – cast predominantly base metal	185	85	100	150	185	225	245
D6212	pontic – cast noble metal	185	85	100	150	185	225	245
D6214	pontic – titanium	185	85	100	150	185	225	245
D6240	pontic – porcelain fused to high noble metal	185	85	100	150	185	225	245
D6241	pontic – porcelain fused to predominantly base metal	185	85	100	150	185	225	245
D6242	pontic – porcelain fused to noble metal	185	85	100	150	185	225	245
D6245	pontic – porcelain/ceramic	185	105	120	170	205	245	245
D6250	pontic – resin with high noble metal	185	85	100	150	185	225	NTCV
D6251	pontic – resin with predominantly base metal	185	85	100	150	185	225	NTCV
D6252	pontic – resin with noble metal	185	85	100	150	185	225	NTCV
D6253	provisional pontic – further treatment or completion of diagnosis necessary prior to final impression	185	0	0	0	0	0	NTCV
D6545	retainer – cast metal for resin bonded fixed prosthesis	185	85	100	150	150	150	NTCV
D6549	resin retainer – for resin bonded fixed prosthesis		85	100	150	150	150	245
D6600	retainer inlay – porcelain/ceramic, two surfaces	185	85	100	150	185	225	NTCV
D6601	retainer inlay – porcelain/ceramic, three or more surfaces	185	85	100	150	185	225	NTCV
D6602	retainer inlay – cast high noble metal, two surfaces	185	85	100	150	185	225	NTCV
D6603	retainer inlay – cast high noble metal, three or more surfaces	185	85	100	150	185	225	NTCV
D6604	retainer inlay – cast predominantly base metal, two surfaces	185	85	100	150	185	225	NTCV
D6605	retainer inlay – cast predominantly base metal, three or more surfaces	185	85	100	150	185	225	NTCV
D6606	retainer inlay – cast noble metal, two surfaces	185	85	100	150	185	225	NTCV
D6607	retainer inlay – cast noble metal, three or more surfaces	185	85	100	150	185	225	NTCV
D6608	retainer onlay – porcelain/ceramic, two surfaces	185	85	100	150	185	225	NTCV
D6609	retainer onlay – porcelain/ceramic, three or more surfaces	185	85	100	150	185	225	NTCV
D6610	retainer onlay – cast high noble metal, two surfaces	185	85	100	150	185	225	NTCV

HEALTH NET OF CA DHMO
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS



EXHIBIT 2 - PART II

CDT CODE	Plan Name: Agreement ID:	Minimum Guarantee	HN Plus DHMO 85	HN Plus DHMO 100	HN Plus DHMO 150	HN Plus DHMO 185	HN Plus DHMO 225	HN FB DHMO Preferred
			SCFG00000196	SCFG00000197	SCFG00000198	SCFG00000199	SCFG00000200	SCFG00000202
D6611	retainer onlay – cast high noble metal, three or more surfaces	185	85	100	150	185	225	NTCV
D6612	retainer onlay – cast predominantly base metal, two surfaces	185	85	100	150	185	225	NTCV
D6613	retainer onlay – cast predominantly base metal, three or more surfaces	185	85	100	150	185	225	NTCV
D6614	retainer onlay – cast noble metal, two surfaces	185	85	100	150	185	225	NTCV
D6615	retainer onlay – cast noble metal, three or more surfaces	185	85	100	150	185	225	NTCV
D6710	retainer crown – indirect resin based composite	185	85	100	150	185	225	NTCV
D6720	retainer crown – resin with high noble metal	185	85	100	150	185	225	NTCV
D6721	retainer crown – resin with predominantly base metal	185	85	100	150	185	225	245
D6722	retainer crown – resin with noble metal	185	85	100	150	185	225	NTCV
D6740	retainer crown – porcelain/ceramic	185	85	100	150	185	225	NTCV
D6750	retainer crown – porcelain fused to high noble metal	185	85	100	150	185	225	245
D6751	retainer crown – porcelain fused to predominantly base metal	185	85	100	150	185	225	245
D6752	retainer crown – porcelain fused to noble metal	185	85	100	150	185	225	245
D6780	retainer crown – ¾ cast high noble metal	185	85	100	150	185	225	245
D6781	retainer crown – ¾ cast predominantly base metal	185	85	100	150	185	225	245
D6782	retainer crown – ¾ cast noble metal	185	85	100	150	185	225	245
D6783	retainer crown – ¾ porcelain/ceramic	185	85	100	150	185	225	NTCV
D6790	retainer crown – full cast high noble metal	185	85	100	150	185	225	245
D6791	retainer crown – full cast predominantly base metal	185	85	100	150	185	225	245
D6792	retainer crown – full cast noble metal	185	85	100	150	185	225	245
D6794	retainer crown – titanium		85	100	150	185	225	245
D6930	re-cement or re-bond fixed partial denture		0	0	0	0	0	15
D6940	stress breaker		110	110	110	110	110	NTCV
D6950	precision attachment		195	195	195	195	195	NTCV
D6980	fixed partial denture repair necessitated by restorative material failure		0	45	45	45	45	45
X. ORAL AND MAXILLOFACIAL SURGERY								
<ul style="list-style-type: none"> The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of your Health Net selected general or specialty care dentist's usual and customary fees. 								
D7111	extraction, coronal remnants – primary tooth		0	0	0	5	5	5
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	15	0	0	0	0	0	5
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		5	15	30	30	30	30
D7220	removal of impacted tooth – soft tissue		10	20	35	45	45	50
D7230	removal of impacted tooth – partially bony		30	40	65	65	65	65
D7240	removal of impacted tooth – completely bony		55	75	80	80	80	80

**HEALTH NET OF CA DHMO
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**



EXHIBIT 2 - PART II

CDT CODE	Plan Name: Agreement ID:	Minimum Guarantee	HN Plus DHMO 85	HN Plus DHMO 100	HN Plus DHMO 150	HN Plus DHMO 185	HN Plus DHMO 225	HN FB DHMO Preferred
			SCFG00000196	SCFG00000197	SCFG00000198	SCFG00000199	SCFG00000200	SCFG00000202
D7241	removal of impacted tooth – completely bony, with unusual surgical complications		80	90	90	100	100	100
D7250	removal of residual tooth roots (cutting procedure)		5	5	35	40	40	40
D7251	coronectomy – intentional partial tooth removal		5	5	35	40	40	40
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth		15	15	15	50	50	50
D7280	exposure of an unerupted tooth		15	15	15	85	85	200
D7282	mobilization of erupted or malpositioned tooth to aid eruption		15	15	90	90	90	NTCV
D7283	placement of device to facilitate eruption of impacted tooth		15	15	90	90	90	NTCV
D7285	incisional biopsy of oral tissue – hard (bone, tooth)		0	0	0	0	0	150
D7286	incisional biopsy of oral tissue – soft		0	0	0	0	0	150
D7287	exfoliative cytological sample collection		50	50	50	50	50	50
D7288	brush biopsy – transepithelial sample collection		50	50	50	50	50	50
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		0	0	0	35	40	40
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		0	0	0	10	15	15
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		0	0	0	40	60	60
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		0	0	0	20	25	25
D7471	removal of lateral exostosis (maxilla or mandible)		80	80	80	80	80	NTCV
D7472	removal of torus palatinus		15	15	60	60	60	NTCV
D7473	removal of torus mandibularis		15	15	60	60	60	NTCV
D7485	reduction of osseous tuberosity		60	60	60	60	60	NTCV
D7510	incision and drainage of abscess – intraoral soft tissue		15	15	15	30	35	35
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		15	15	15	30	35	NTCV
D7520	incision and drainage of abscess – extraoral soft tissue		15	15	15	30	35	NTCV
D7521	incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		15	15	15	30	35	NTCV
D7881	occlusal orthotic device adjustment		0	0	0	0	10	10
D7910	suture of recent small wounds up to 5 cm		15	15	15	25	25	NTCV
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure		0	0	0	40	40	50
D7963	frenuloplasty		0	0	0	40	40	50
D7970	excision of hyperplastic tissue – per arch		55	55	55	55	55	NTCV

**HEALTH NET OF CA DHMO
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**



EXHIBIT 2 - PART II

CDT CODE	Plan Name: Agreement ID:	Minimum Guarantee	HN Plus DHMO 85	HN Plus DHMO 100	HN Plus DHMO 150	HN Plus DHMO 185	HN Plus DHMO 225	HN FB DHMO Preferred
			SCFG00000196	SCFG00000197	SCFG00000198	SCFG00000199	SCFG00000200	SCFG00000202
D7971	excision of pericoronal gingiva		35	35	35	35	40	40
XII. ADJUNCTIVE GENERAL SERVICES								
D9110	palliative (emergency) treatment of dental pain – minor procedure		0	0	0	0	0	10
D9120	fixed partial denture sectioning		0	0	0	0	0	0
D9210	local anesthesia not in conjunction with operative or surgical procedures		0	0	0	0	0	NTCV
D9211	regional block anesthesia		0	0	0	0	0	NTCV
D9212	trigeminal division block anesthesia		0	0	0	0	0	NTCV
D9215	local anesthesia in conjunction with operative or surgical procedures		0	0	0	0	0	0
D9219	evaluation for deep sedation or general anesthesia		0	0	0	0	0	0
D9222	deep sedation/general anesthesia – first 15 minutes		45	45	45	45	45	45
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment		45	45	45	45	45	45
D9230	inhalation of nitrous oxide/anxiolysis, analgesia		15	15	15	15	15	15
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes		45	45	45	45	45	45
D9243	intravenous moderate (conscious) sedation/anesthesia – each subsequent 15 minute increment		45	45	45	45	45	45
D9248	non-intravenous conscious sedation		15	15	15	15	15	15
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		0	0	0	0	0	0
D9311	consultation with a medical health care professional		0	0	0	0	0	5
D9430	office visit for observation (during regularly scheduled hours) – no other services performed		0	0	0	0	0	5
D9440	office visit – after regularly scheduled hours		15	15	15	30	30	30
D9450	case presentation, detailed and extensive treatment planning		0	0	0	0	0	0
D9610	therapeutic parenteral drug, single administration		15	15	15	15	15	NTCV
D9612	therapeutic parenteral drugs, two or more administrations, different medications		25	25	25	25	25	NTCV
D9613	infiltration of sustained release therapeutic drug – single or multiple sites		15	15	15	15	15	NTCV
D9630	drugs or medicaments dispensed in the office for home use		15	15	15	15	15	15
D9910	application of desensitizing medicament		15	15	15	15	15	NTCV
D9942	repair and/or reline of occlusal guard		40	40	40	40	40	NTCV
D9943	occlusal guard adjustment		0	0	0	0	10	10
D9944	occlusal guard – hard appliance, full arch		85	85	85	85	85	85
D9945	occlusal guard – soft appliance, full arch		85	85	85	85	85	85
D9946	occlusal guard – hard appliance, partial arch		43	43	43	43	43	43
D9951	occlusal adjustment – limited		0	0	0	15	30	30
D9952	occlusal adjustment – complete		0	0	0	50	60	100

HEALTH NET OF CA DHMO
 PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS



EXHIBIT 2 - PART II

CDT CODE	Plan Name: Agreement ID:	Minimum Guarantee	HN Plus DHMO 85	HN Plus DHMO 100	HN Plus DHMO 150	HN Plus DHMO 185	HN Plus DHMO 225	HN FB DHMO Preferred
			SCFG00000196	SCFG00000197	SCFG00000198	SCFG00000199	SCFG00000200	SCFG00000202
D9972	external bleaching – per arch – performed in office		125	125	125	125	125	125
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays		125	125	125	125	125	125
D9995	teledentistry – synchronous; real-time encounter		0	0	0	0	0	5
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review		0	0	0	0	0	5
	broken appointment (less than 24 hour notice) not to exceed		10	10	10	25	25	25

MINIMUM GUARANTEE NOTES:

1	Reimbursement for only two (2) quadrants per visit. A maximum of four (4) quadrants will be paid in any combination per calendar year. A copy of periodontal charting is required for reimbursement. Additional documentation may be required on a case by case basis.
	• Submit the minimum guarantee reimbursement for crowns, abutment crowns, pontics, inlays, and onlays at final insertion / completion of the procedure.

Example: D2750 - Crown - Porcelain fused to high noble metal*	
Minimum Guarantee	\$185
Member Copayment to your office	\$85
Plan Pays your office upon receipt of claim	\$100

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.

**HEALTH NET OF CA DHMO
LIMITATIONS AND EXCLUSIONS OF BENEFITS
EXHIBIT 2**



**HN PLUS DHMO 85 - HN PLUS DHMO 225,
HN FB DHMO PREFERRED
LIMITATION OF BENEFITS**

Listed below are limitations on services covered under the plan.

GENERAL

1. Any procedures not specifically listed as a covered benefit in this Plan's Schedule of Benefits are available at 75% of the usual and customary fees of the treating Dental Benefit Provider selected general or specialty care dentist, provided the services are included in the treatment plan and are not specifically excluded.
2. Dental procedures or services performed solely for cosmetic purposes or solely for appearance are available at 75% of the usual and customary fees of the treating Dental Benefit Provider selected general or specialty care dentist, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits.
3. General anesthesia is a covered benefit only when administered by the treating dentist, in conjunction with oral and periodontal surgical procedures.

PREVENTIVE

1. Routine Cleanings (prophylaxis), periodontal maintenance services, and fluoride treatments are limited to twice a year. Two (2) additional cleanings (routine and periodontal) are available at the copayment listed on this Plan's Schedule of Benefits. Additional prophylaxis are available, if medically necessary.
2. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption, unless medically necessary.

DIAGNOSTIC

1. Panoramic or full-mouth X-rays: Once every three (3) years, unless medically necessary.

RESTORATIVE

1. An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal.
2. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
3. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional \$125 copayment per unit in addition to the specified copayment for each crown/bridge unit.
4. There is a \$75 copayment per crown/bridge unit in addition to the specified copayment for porcelain on molars.

ENDODONTICS

1. The copayments listed for endodontic procedures do not include the cost of the final restoration.

PROSTHODONTICS

1. Relines are limited to one (1) every twelve (12) months.
2. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a Dental Benefit Provider Plan, unless due to the loss of a natural functioning tooth. Replacements will be a benefit under this Plan only if the existing denture is unsatisfactory and cannot be made satisfactory as determined by the treating Dental Benefit Provider selected general dentist.
3. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.

ORAL SURGERY

1. The removal of asymptomatic third molars is not a covered benefit unless pathology disease exists, however it is available at 75% of your Dental Benefit Provider selected general or specialty care dentist's usual and customary fees.

**HEALTH NET OF CA DHMO
LIMITATIONS AND EXCLUSIONS OF BENEFITS
EXHIBIT 2**



**HN PLUS DHMO 85 - HN PLUS DHMO 225,
HN FB DHMO PREFERRED
EXCLUSION OF BENEFITS**

Listed below are those services or expenses NOT covered under the plan that become the responsibility of the member at the dentist's Usual and Customary fee.

1. Services performed by any dentist not contracted with Health Net, without prior approval (except out-of-area emergency services). This includes services performed by a general dentist or specialty care dentist.
2. Dental procedures started prior to the member's eligibility under this Plan or started after the member's termination from the Plan. Examples include: teeth prepared for crowns, root canals, in progress, full or partial dentures for which an impression has been taken.
3. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the Dental Benefit Provider selected general dentist.
4. Orthognathic surgery.
5. Inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
6. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged due to abuse, misuse, or neglect.
7. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits. Any services related to pathology laboratory fees.
8. Procedures, appliances, or restorations whose primary main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits.
9. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
10. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
11. Dental services required while serving in the Armed Forces of any country or international authority.
12. Dental services considered experimental in nature.
13. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member.

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.

**HEALTH NET OF CA / CENTENE DHMO
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
EXHIBIT 2 - PART III**

CDT CODE	Plan Name:	Minimum	HN FB DHMO	HN Group Plan 90-SD	HN GEMINI DHMO 50-S	HN IFP DHMO Adult Buy Up
	Agreement ID:	Guarantee	SCFG00000201	SCFG00000203	SCFG00000205	SCFG00000206
	PLAN TYPE:		Commercial	Commercial	Commercial	IFP Commercial
	MINIMUM GUARANTEE:		YES	YES	YES	YES
	SPECIALTY REFERRAL:		DIRECT	DIRECT	PRE-AUTH	Pre-Auth (Ortho Benefit Only)
CDT codes not listed are not a covered benefit / NTCV = Not Covered						
I. DIAGNOSTIC						
D0120	periodic oral evaluation – established patient		0	0	0	0
D0140	limited oral evaluation – problem focused		0	0	0	0
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver		0	NTCV	NTCV	0
D0150	comprehensive oral evaluation – new or established patient		0	0	0	0
D0160	detailed and extensive oral evaluation – problem focused, by report		0	0	NTCV	NTCV
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)		0	0	0	NTCV
D0171	re-evaluation – post-operative office visit		5	0	0	NTCV
D0180	comprehensive periodontal evaluation – new or established patient		5	0	0	NTCV
D0190	screening of a patient		5	0	0	NTCV
D0191	assessment of a patient		5	0	0	NTCV
D0210	intraoral – complete series of radiographic images		0	0	0	0
D0220	intraoral – periapical first radiographic image		0	0	0	0
D0230	intraoral – periapical each additional radiographic image		0	0	0	0
D0240	intraoral – occlusal radiographic image		0	0	0	0
D0270	bitewing – single radiographic image		0	0	0	0
D0272	bitewings – two radiographic images		0	0	0	0
D0273	bitewings – three radiographic images		0	NTCV	NTCV	0
D0274	bitewings – four radiographic images		0	0	0	0
D0330	panoramic radiographic image		0	NTCV	0	0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally		0	NTCV	0	0
D0351	3D photographic image		0	NTCV	0	0
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report		20	0	0	NTCV
D0411	HbA1c in-office point of service testing		0	0	0	0
D0415	collection of microorganisms for culture and sensitivity		NTCV	0	NTCV	NTCV
D0417	collection and preparation of saliva sample for laboratory diagnostic testing		NTCV	0	NTCV	NTCV
D0418	analysis of saliva sample		NTCV	0	NTCV	NTCV
D0460	pulp vitality tests		0	0	0	0
D0470	diagnostic casts		0	NTCV	5	0
D0472	accession of tissue, gross examination, preparation and transmission of written report		0	NTCV	NTCV	NTCV

HEALTH NET OF CA / CENTENE DHMO
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
EXHIBIT 2 - PART III

CDT CODE	Plan Name: Agreement ID:	Minimum	HN FB DHMO	HN Group Plan 90-SD	HN GEMINI DHMO 50-S	HN IFP DHMO Adult Buy Up
		Guarantee	SCFG00000201	SCFG00000203	SCFG00000205	SCFG00000206
D0473	accession of tissue, gross and microscopic examination, preparation and transmission of written report		0	0	NTCV	0
D0474	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report		NTCV	0	NTCV	0
D0486	laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.		0	NTCV	NTCV	0
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum		0	0	0	0
D0601	caries risk assessment and documentation, with a finding of low risk		0	0	0	0
D0602	caries risk assessment and documentation, with a finding of moderate risk		0	0	0	0
D0603	caries risk assessment and documentation, with a finding of high risk		0	0	0	0
D0999	office visit fee - per visit	2	0	0	0	0
II. PREVENTIVE						
* Prophylaxis is limited to: a) one initial treatment every 12 months, and b) one "second" treatment every 12 months.						
D1110	prophylaxis – adult		0	0	0	8*
D1110	prophylaxis – adult - In addition to plan limitation listed above†		NTCV	NTCV	NTCV	23*
D1120	prophylaxis – child		0	0	0	8*
D1120	prophylaxis – child - In addition to plan limitation listed above†		NTCV	NTCV	NTCV	23*
D1206	topical application of fluoride varnish		0	NTCV	NTCV	3
D1208	topical application of fluoride – excluding varnish		0	0	0	3
D1310	nutritional counseling for control of dental disease		NTCV	NTCV	0	0
D1320	tobacco counseling for the control and prevention of oral disease		NTCV	NTCV	0	NTCV
D1330	oral hygiene instructions		0	0	0	0
D1351	sealant – per tooth		10	NTCV	6	5
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth		10	NTCV	6	5
D1353	sealant repair – per tooth		10	NTCV	6	5
D1510	space maintainer – fixed, unilateral		40	0	35	75
D1516	space maintainer – fixed – bilateral, maxillary		40	0	45	155
D1517	space maintainer – fixed – bilateral, mandibular		40	0	45	155
D1520	space maintainer – removable – unilateral		40	0	37	100
D1526	space maintainer – removable – bilateral, maxillary		40	0	50	170
D1527	space maintainer – removable – bilateral, mandibular		40	0	50	170
D1550	re-cement or re-bond space maintainer		10	NTCV	0	15
D1555	removal of fixed space maintainer		10	NTCV	NTCV	15
D1575	distal shoe space maintainer – fixed – unilateral		40	0	35	75

HEALTH NET OF CA / CENTENE DHMO
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
EXHIBIT 2 - PART III

CDT CODE	Plan Name:	Minimum Guarantee	HN FB DHMO	HN Group Plan 90-SD	HN GEMINI DHMO 50-S	HN IFP DHMO Adult Buy Up
			SCFG00000201	SCFG00000203	SCFG00000205	SCFG00000206
III. RESTORATIVE						
<ul style="list-style-type: none"> • Lab reimbursement - Dental copayments have an additional charge not to exceed the actual lab cost for noble and high noble metals and a \$75 fee applies per crown for porcelain on molars. • HN FB DHMO plan: Cases involving 7 or more crowns in the same treatment plan require an additional \$125 fee per unit in addition to the copayment. 						
† Copayments reflect primary versus permanent tooth copayment.						
D2140	amalgam – one surface, primary or permanent		0	0	0	20/25†
D2150	amalgam – two surfaces, primary or permanent		0	0	0	25/32†
D2160	amalgam – three surfaces, primary or permanent		0	0	0	37/41†
D2161	amalgam – four or more surfaces, primary or permanent		0	0	10	37/49†
D2330	resin-based composite – one surface, anterior		0	0	14	35
D2331	resin-based composite – two surfaces, anterior		0	0	18	45
D2332	resin-based composite – three surfaces, anterior		0	0	25	55
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		0	0	35	65
D2390	resin-based composite crown, anterior		0	NTCV	NTCV	NTCV
D2391	resin-based composite – one surface, posterior		65	NTCV	NTCV	40/55†
D2392	resin-based composite – two surfaces, posterior		75	NTCV	NTCV	55/70†
D2393	resin-based composite – three surfaces, posterior		80	NTCV	NTCV	70/85†
D2394	resin-based composite – four or more surfaces, posterior		80	NTCV	NTCV	70/85†
D2510	inlay – metallic – one surface		130	NTCV	NTCV	NTCV
D2520	inlay – metallic – two surfaces		140	NTCV	NTCV	NTCV
D2530	inlay – metallic – three or more surfaces		150	NTCV	NTCV	NTCV
D2542	onlay – metallic – two surfaces		146	50	120	NTCV
D2543	onlay – metallic – three surfaces		156	50	125	NTCV
D2544	onlay – metallic – four or more surfaces		162	50	132	NTCV
D2610	inlay – porcelain/ceramic – one surface		496	NTCV	NTCV	NTCV
D2620	inlay – porcelain/ceramic – two surfaces		524	NTCV	NTCV	NTCV
D2630	inlay – porcelain/ceramic – three or more surfaces		558	NTCV	NTCV	NTCV
D2642	onlay – porcelain/ceramic – two surfaces		542	50	NTCV	NTCV
D2643	onlay – porcelain/ceramic – three surfaces		585	50	NTCV	NTCV
D2644	onlay – porcelain/ceramic – four or more surfaces		620	50	NTCV	NTCV
D2650	inlay – resin-based composite – one surface		326	NTCV	NTCV	NTCV
D2651	inlay – resin-based composite – two surfaces		388	NTCV	NTCV	NTCV
D2652	inlay – resin-based composite – three or more surfaces		408	NTCV	NTCV	NTCV
D2662	onlay – resin-based composite – two surfaces		354	50	NTCV	NTCV
D2663	onlay – resin-based composite – three surfaces		417	50	NTCV	NTCV
D2664	onlay – resin-based composite – four or more surfaces		446	50	NTCV	NTCV
D2710	crown – resin-based composite (indirect)		110	20	70	240

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		Guarantee	SCFG00000201	SCFG00000203	SCFG00000205	SCFG00000206
D2712	crown – ¾ resin-based composite (indirect)		195	50	NTCV	240
D2720	crown – resin with high noble metal		195	NTCV	NTCV	240
D2721	crown – resin with predominantly base metal		195	NTCV	NTCV	240
D2722	crown – resin with noble metal		195	NTCV	NTCV	240
D2740	crown – porcelain/ceramic		195	NTCV	150	NTCV
D2750	crown – porcelain fused to high noble metal	130	195	50	110	305
D2751	crown – porcelain fused to predominantly base metal	130	195	50	110	305
D2752	crown – porcelain fused to noble metal	130	195	50	110	305
D2780	crown – ¾ cast high noble metal	130	195	50	95	280
D2781	crown – ¾ cast predominantly base metal	130	195	50	95	280
D2782	crown – ¾ cast noble metal	130	195	50	95	280
D2783	crown – ¾ porcelain/ceramic	130	NTCV	50	95	NTCV
D2790	crown – full cast high noble metal	130	195	50	100	280
D2791	crown – full cast predominantly base metal	130	195	50	100	280
D2792	crown – full cast noble metal	130	195	50	100	280
D2794	crown – titanium	130	195	50	100	280
D2799	provisional crown– further treatment or completion of diagnosis necessary prior to final impression		NTCV	NTCV	25	NTCV
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		10	NTCV	10	15
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		10	NTCV	10	15
D2920	re-cement or re-bond crown		10	0	10	21
D2921	reattachment of tooth fragment, incisal edge or cusp		15	NTCV	25	NTCV
D2930	prefabricated stainless steel crown – primary tooth		35	0	36	55
D2931	prefabricated stainless steel crown – permanent tooth		35	0	36	65
D2932	prefabricated resin crown		45	NTCV	NTCV	NTCV
D2933	prefabricated stainless steel crown with resin window		35	NTCV	NTCV	NTCV
D2940	protective restoration		0	0	3	20
D2941	interim therapeutic restoration – primary dentition		0	0	3	20
D2950	core buildup, including any pins when required		15	0	5	23
D2951	pin retention – per tooth, in addition to restoration		15	0	0	20
D2952	post and core in addition to crown, indirectly fabricated		15	40	50	100
D2953	each additional indirectly fabricated post – same tooth		15	40	25	100
D2954	prefabricated post and core in addition to crown		15	20	36	60
D2955	post removal		NTCV	NTCV	0	NTCV
D2957	each additional prefabricated post – same tooth		15	20	17	60
D2980	crown repair necessitated by restorative material failure		15	NTCV	25	NTCV
D2981	inlay repair necessitated by restorative material failure		15	NTCV	25	NTCV

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D2982	onlay repair necessitated by restorative material failure		15	NTCV	25	NTCV
D2990	resin infiltration of incipient smooth surface lesions		10	NTCV	6	5
IV. ENDODONTICS						
* Copayment is based upon whether root canal therapy is either a single root, double root or tri-rooted therapy.						
D3110	pulp cap – direct (excluding final restoration)		0	0	0	21
D3120	pulp cap – indirect (excluding final restoration)		0	0	0	21
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament		5	0	15	33
D3221	pulpal debridement, primary and permanent teeth		5	0	15	NTCV
D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		5	30/50/60*	20	NTCV
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)		5	30/50/60*	23	NTCV
D3310	endodontic therapy, anterior tooth (excluding final restoration)		75	30	95	170
D3320	endodontic therapy, premolar tooth (excluding final restoration)		120	30/50*	120	220
D3330	endodontic therapy, molar tooth (excluding final restoration)	265	180	30/50/60*	150	290
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		75	60	95	170
D3346	retreatment of previous root canal therapy – anterior		95	30	100	185
D3347	retreatment of previous root canal therapy – premolar		140	30/50*	125	240
D3348	retreatment of previous root canal therapy – molar		200	30/50/60*	175	315
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)		NTCV	0	30	NTCV
D3352	apexification/recalcification – interim medication replacement		NTCV	0	30	NTCV
D3353	apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)		NTCV	0	30	NTCV
D3410	apicoectomy – anterior		85	30	75	155
D3421	apicoectomy – premolar (first root)		85	30	75	155
D3425	apicoectomy – molar (first root)		85	30	75	155
D3426	apicoectomy (each additional root)		50	30	45	75
D3427	periradicular surgery without apicoectomy		50	30	45	75
D3430	retrograde filling – per root		50	30	30	48
D3450	root amputation – per root		60	0	100	85
D3920	hemisection (including any root removal), not including root canal therapy		NTCV	0	65	85
V. PERIODONTICS - Includes periodontal charting for planning treatment of periodontal disease and periodontal hygiene instruction						
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant		125	0	95	230
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant		25	0	16	33

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D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant		135	NTCV	15	30
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant		135	NTCV	15	30
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant		250	85	80	290
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant		250	85	80	290
D4341	periodontal scaling and root planing – four or more teeth per quadrant	25 ¹	45	0	25	30
D4342	periodontal scaling and root planing – one to three teeth per quadrant		45	0	25	30
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		36	NTCV	22	NTCV
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit		45	0	0	20
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth		NTCV	NTCV	NTCV	NTCV
D4910	periodontal maintenance		36	NTCV	22	NTCV
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)		NTCV	0	NTCV	NTCV
D4921	gingival irrigation - per quadrant		0	0	0	0
VI. PROSTHODONTICS (REMOVABLE) - Includes up to 3 adjustments within 6 months of delivery.						
D5110	complete denture – maxillary	110	225	60	125	405
D5120	complete denture – mandibular	110	225	60	125	405
D5130	immediate denture – maxillary		300	60	145	420
D5140	immediate denture – mandibular		300	60	145	420
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		245	80	90	290
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		245	80	90	290
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	120	275	80	120	385
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	120	275	80	120	385
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		0	NTCV	50	135
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		0	NTCV	50	135
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		0	NTCV	50	135

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D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		0	NTCV	50	135
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary		NTCV	0	90	NTCV
D5283	removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular		NTCV	0	90	NTCV
D5410	adjust complete denture – maxillary		10	0	5	15
D5411	adjust complete denture – mandibular		10	0	5	15
D5421	adjust partial denture – maxillary		10	0	5	15
D5422	adjust partial denture – mandibular		10	0	5	15
D5511	repair broken complete denture base, mandibular		10	0	5	15
D5512	repair broken complete denture base, maxillary		10	0	5	15
D5520	replace missing or broken teeth – complete denture (each tooth)		10	0	10	53
D5611	repair resin partial denture base, mandibular		10	0	5	15
D5612	repair resin partial denture base, maxillary		10	0	5	15
D5621	repair cast partial framework, mandibular		10	0	5	15
D5622	repair cast partial framework, maxillary		10	0	5	15
D5630	repair or replace broken clasp – per tooth		24	0	10	63
D5640	replace broken teeth – per tooth		10	0	20	53
D5650	add tooth to existing partial denture		10	0	15	58
D5660	add clasp to existing partial denture – per tooth		10	NTCV	10	63
D5670	replace all teeth and acrylic on cast metal framework (maxillary)		NTCV	NTCV	NTCV	185
D5671	replace all teeth and acrylic on cast metal framework (mandibular)		NTCV	NTCV	NTCV	185
D5710	rebase complete maxillary denture		50	20	40	185
D5711	rebase complete mandibular denture		50	20	40	185
D5720	rebase maxillary partial denture		50	20	40	185
D5721	rebase mandibular partial denture		50	20	40	185
D5730	reline complete maxillary denture (chairside)		30	0	5	70
D5731	reline complete mandibular denture (chairside)		30	0	5	70
D5740	reline maxillary partial denture (chairside)		30	0	5	70
D5741	reline mandibular partial denture (chairside)		30	0	5	70
D5750	reline complete maxillary denture (laboratory)		30	20	40	120
D5751	reline complete mandibular denture (laboratory)		50	20	40	120
D5760	reline maxillary partial denture (laboratory)		50	20	40	120
D5761	reline mandibular partial denture (laboratory)		50	20	40	120
D5820	interim partial denture (maxillary)		0	NTCV	50	135
D5821	interim partial denture (mandibular)		0	NTCV	50	135
D5850	tissue conditioning, maxillary		10	NTCV	10	40

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D5851	tissue conditioning, mandibular		10	NTCV	10	40
D5863	overdenture - complete maxillary		225	60	125	405
D5864	overdenture - complete mandibular		275	80	120	385
D5865	overdenture - partial maxillary		225	60	125	405
D5866	overdenture - partial mandibular		275	80	120	385
D5876	add metal substructure to acrylic full denture (per arch)		50	20	40	185

IX. PROSTHODONTICS, FIXED

- Lab reimbursement - Dental copayments have an additional charge not to exceed the actual lab cost for noble and high noble metals and a \$75 fee applies per crown for porcelain on molars.
- HN FB DHMO plan: Cases involving 7 or more crowns in the same treatment plan require an additional \$125 fee per unit in addition to the copayment.

D6205	pontic – indirect resin based composite		195	NTCV	90	280
D6210	pontic – cast high noble metal		195	50	90	280
D6211	pontic – cast predominantly base metal		195	50	90	280
D6212	pontic – cast noble metal		195	50	90	280
D6214	pontic – titanium		195	50	90	305
D6240	pontic – porcelain fused to high noble metal		195	50	99	305
D6241	pontic – porcelain fused to predominantly base metal		195	50	99	305
D6242	pontic – porcelain fused to noble metal		195	50	99	305
D6245	pontic – porcelain/ceramic		195	NTCV	NTCV	NTCV
D6250	pontic – resin with high noble metal		195	NTCV	NTCV	NTCV
D6251	pontic – resin with predominantly base metal		195	NTCV	NTCV	NTCV
D6252	pontic – resin with noble metal		195	NTCV	NTCV	NTCV
D6545	retainer – cast metal for resin bonded fixed prosthesis		NTCV	NTCV	90	NTCV
D6600	retainer inlay – porcelain/ceramic, two surfaces		140	NTCV	NTCV	NTCV
D6602	retainer inlay – cast high noble metal, two surfaces		140	NTCV	NTCV	NTCV
D6603	retainer inlay – cast high noble metal, three or more surfaces		150	NTCV	NTCV	NTCV
D6604	retainer inlay – cast predominantly base metal, two surfaces		140	NTCV	NTCV	NTCV
D6605	retainer inlay – cast predominantly base metal, three or more surfaces		150	NTCV	NTCV	NTCV
D6606	retainer inlay – cast noble metal, two surfaces		140	NTCV	NTCV	NTCV
D6607	retainer inlay – cast noble metal, three or more surfaces		150	NTCV	NTCV	NTCV
D6608	retainer onlay – porcelain/ceramic, two surfaces		156	50	NTCV	NTCV
D6609	retainer onlay – porcelain/ceramic, three or more surfaces		156	50	NTCV	NTCV
D6610	retainer onlay – cast high noble metal, two surfaces		156	50	NTCV	NTCV
D6611	retainer onlay – cast high noble metal, three or more surfaces		156	50	NTCV	NTCV
D6612	retainer onlay – cast predominantly base metal, two surfaces		156	50	NTCV	NTCV
D6613	retainer onlay – cast predominantly base metal, three or more surfaces		156	50	NTCV	NTCV
D6614	retainer onlay – cast noble metal, two surfaces		156	50	NTCV	NTCV

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D6615	retainer onlay – cast noble metal, three or more surfaces		156	50	NTCV	NTCV
D6634	retainer onlay – titanium		NTCV	50	NTCV	NTCV
D6710	retainer crown – indirect resin based composite		195	50	110	305
D6720	retainer crown – resin with high noble metal		195	NTCV	NTCV	NTCV
D6721	retainer crown – resin with predominantly base metal		195	NTCV	NTCV	NTCV
D6722	retainer crown – resin with noble metal		195	NTCV	NTCV	NTCV
D6740	retainer crown – porcelain/ceramic		195	NTCV	NTCV	NTCV
D6750	retainer crown – porcelain fused to high noble metal		195	50	110	305
D6751	retainer crown – porcelain fused to predominantly base metal		195	NTCV	110	305
D6752	retainer crown – porcelain fused to noble metal		195	50	110	305
D6780	retainer crown – ¾ cast high noble metal		195	50	95	280
D6781	retainer crown – ¾ cast predominantly base metal		195	50	95	280
D6782	retainer crown – ¾ cast noble metal		195	50	95	280
D6783	retainer crown – ¾ porcelain/ceramic		NTCV	50	NTCV	NTCV
D6790	retainer crown – full cast high noble metal		195	50	100	280
D6791	retainer crown – full cast predominantly base metal		195	50	100	280
D6792	retainer crown – full cast noble metal		195	50	100	280
D6794	retainer crown – titanium		195	50	100	280
D6930	re-cement or re-bond fixed partial denture		15	0	5	23
D6940	stress breaker		25	0	NTCV	NTCV
D6980	fixed partial denture repair necessitated by restorative material failure		20	NTCV	NTCV	NTCV
X. ORAL AND MAXILLOFACIAL SURGERY - includes routine post operative treatment.						
* Copayment for first extraction and each additional extraction.						
D7111	extraction, coronal remnants – primary tooth		6	0	8	35
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)		6	0	8/5*	35/27*
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		15	10	20	50
D7220	removal of impacted tooth – soft tissue		40	25	30	70
D7230	removal of impacted tooth – partially bony		60	25	45	105
D7240	removal of impacted tooth – completely bony		80	30	55	135
D7241	removal of impacted tooth – completely bony, with unusual surgical complications		80	NTCV	NTCV	NTCV
D7250	removal of residual tooth roots (cutting procedure)		0	25	15	50
D7251	coronectomy – intentional partial tooth removal		0	25	15	50
D7285	incisional biopsy of oral tissue – hard (bone, tooth)		NTCV	0	50	NTCV
D7286	incisional biopsy of oral tissue – soft		20	0	50	NTCV
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		40	NTCV	20	NTCV
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		15	NTCV	7	NTCV

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D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per		60	0	40	NTCV
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per		20	0	14	NTCV
D7340	vestibuloplasty – ridge extension (secondary epithelialization)		NTCV	0	NTCV	NTCV
D7471	removal of lateral exostosis (maxilla or mandible)		50	NTCV	35	NTCV
D7472	removal of torus palatinus		NTCV	0	25	NTCV
D7473	removal of torus mandibularis		NTCV	0	25	NTCV
D7485	reduction of osseous tuberosity		NTCV	NTCV	25	NTCV
D7510	incision and drainage of abscess – intraoral soft tissue		0	0	25	NTCV
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		0	0	25	NTCV
D7520	incision and drainage of abscess – extraoral soft tissue		NTCV	0	NTCV	NTCV
D7881	occlusal orthotic device adjustment		10	0	5	15
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure		0	0	20	NTCV
D7963	frenuloplasty		0	0	20	NTCV
D7970	excision of hyperplastic tissue – per arch		NTCV	0	70	NTCV
D7971	excision of pericoronal gingiva		NTCV	0	30	NTCV
XII. ADJUNCTIVE GENERAL SERVICES						
D9110	palliative (emergency) treatment of dental pain – minor procedure		10	0	18	14
D9120	fixed partial denture sectioning		0	NTCV	NTCV	0
D9211	regional block anesthesia		0	NTCV	NTCV	NTCV
D9212	trigeminal division block anesthesia		0	NTCV	NTCV	NTCV
D9215	local anesthesia in conjunction with operative or surgical procedures		0	0	0	NTCV
D9219	evaluation for deep sedation or general anesthesia		20	0	0	NTCV
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		20	0	0	NTCV
D9311	consultation with a medical health care professional		5	0	0	NTCV
D9430	office visit for observation (during regularly scheduled hours) – no other services performed		5	0	0	NTCV
D9440	office visit – after regularly scheduled hours		20	NTCV	30	55
D9450	case presentation, detailed and extensive treatment planning		0	NTCV	NTCV	NTCV
D9930	treatment of complications (post-surgical) – unusual circumstances, by report		NTCV	NTCV	NTCV	11
D9943	occlusal guard adjustment		10	0	5	15
D9951	occlusal adjustment – limited		NTCV	NTCV	NTCV	27
D9952	occlusal adjustment – complete		NTCV	NTCV	NTCV	27
D9972	external bleaching – per arch – performed in office		NTCV	NTCV	125	NTCV
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays		NTCV	NTCV	125	NTCV

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EXHIBIT 2 - PART III**

CDT CODE	Plan Name: Agreement ID:	Minimum	HN FB DHMO	HN Group Plan 90-SD	HN GEMINI DHMO 50-S	HN IFP DHMO Adult Buy Up
		Guarantee	SCFG00000201	SCFG00000203	SCFG00000205	SCFG00000206
D9995	teledentistry – synchronous; real-time encounter		0	0	0	0
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review		0	0	0	0
	Record transfer - transfer of all materials with or without an x-ray(s)		NTCV	NTCV	15	0
	Broken Appointment - less than 24-hours notice / *less than 12-hours notice		10	5*	25	20

MINIMUM GUARANTEE NOTES:

	Submit the minimum guarantee reimbursement for crowns, abutment crowns, pontics, inlays, and onlays at final insertion / completion of the procedure.	
1	Reimbursement for only two (2) quadrants per visit. A maximum of four (4) quadrants will be paid in any combination per calendar year. A copy of periodontal charting is required for reimbursement. Additional documentation may be required on a case by case basis.	
Example:	D2750 - Crown - Porcelain fused to high noble metal*	
	Minimum Guarantee	\$185
	Member Copayment to your office	\$85
	Plan Pays your office upon receipt of claim	\$100

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EXHIBIT 2

HN FB DHMO
LIMITATION OF BENEFITS

Listed below are limitations on services covered under the plan.

1. Full mouth x-rays are limited to one set every 24 consecutive months and include any combination of periapicals, bitewings and/or panoramic film.
2. Bitewing x-rays are limited to two series of four films per 12 month period.
3. Diagnostic casts are limited to aid in diagnosis by the Contracted Dentist for covered benefits.
4. Prophylaxis or periodontal maintenance is limited to two procedures per 12 month period.
5. Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restoration and with the occlusal surface intact, for first molars through age 9 and second molars through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application.
6. Crowns or fixed bridges using noble or high noble metal will have additional fees.
7. There is a \$75 fee per crown unit above co-pay for porcelain on molars.
8. Crowns or fixed bridges are limited to replacement 1 every 5 years.
9. Cases involving (7) or more crowns and/or fixed bridge units in the same treatment plan require additional \$125 copayment per unit in addition to copayment for each crown/bridge unit.
10. With the exception of pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth.
11. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contracted Dentist is not performing root canal therapy.
12. Periodontal scaling and root planning are limited to four quadrants during any 12 month period.
13. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
14. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months.
15. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to: the replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture; or the replacement of permanent tooth/teeth for children under 16 years of age.
16. Retained primary teeth shall be covered as primary teeth.
17. Benefits provided by a Pediatric Dentist are limited to children through age seven following an attempt by the assigned Contracted Dentist to treat the child and upon prior authorization, less applicable prior authorization, less applicable co-payments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
18. Soft tissue management programs are limited to periodontal pocket charting, root planning, scaling, curettage, oral hygiene instruction, periodontal maintenance and/or prophylaxis. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter the benefit for other covered services.
19. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contracted Dentist's facility where the denture was originally delivered.
20. Surgical removal of impacted teeth is not a covered benefit unless pathology (disease) exists.
21. Surgical removal of wisdom teeth/third molar for orthodontic reasons is not a covered benefit.

EXHIBIT 2

HN FB DHMO

EXCLUSION OF BENEFITS

Listed below are those services or expenses NOT covered under the plan that become the responsibility of the member at the Dentist's Usual and Customary fee.

1. Services performed by a non-contracted general dentist or dentist whose practice is limited to providing Specialty Care, without prior approval (except for out of area emergency services).
2. Any dental services, or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the Dental Benefit Providers selected general dentist.
3. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.
4. Dental procedures or services performed solely for cosmetic purposes or solely for appearance.
5. Orthognathic surgery.
6. General anesthesia or intravenous sedation.
7. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
8. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse, or neglect.
9. Treatment of malignancies, cysts, or neoplasms.
10. Procedures, appliances, or restorations whose main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
11. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
12. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
13. Precision attachments.
14. Dental procedures initiated prior to the member's eligibility under this Plan or started after the member's termination from the Plan.
15. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
16. Dental services required while serving in the Armed Forces of any country or international authority or relating to a declared or undeclared war or acts of war.
17. Services considered unnecessary or experimental in nature.
18. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.
19. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member including, but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.
20. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
21. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.
22. Dental services received from any dental facility that is not contracted, unless expressly authorized in writing or as cited under Emergency Services.

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**HEALTH NET OF CA / CENTENE DHMO
LIMITATIONS AND EXCLUSIONS OF BENEFITS
EXHIBIT 2**



**HN GROUP PLAN 90-SD
LIMITATIONS & EXCLUSIONS OF BENEFITS**

1. Services to which the member is entitled under any Worker's Compensation Law or Act. The Plan shall provide the services at the time of need, but the Member shall execute and deliver such documents or take such other action as may be necessary to assure that the Plan is reimbursed for benefits provided by Worker's Compensation. This exclusion does not apply to Medi-Cal program.
2. Services, in which the opinion of the attending dentist are not necessary for the patient's dental health.
3. Temporomandibular joint treatment (T.M.J.).
4. Elective or cosmetic dentistry.
5. Oral Surgery requiring the setting of fractures or dislocations. Orthognathic surgery or extractions solely for orthodontic purposes.
6. Treatment of malignancies, cysts, neoplasms or congenital malformations.
7. Dispensing of drugs.
8. In the event the patient desires to be hospitalized for any dental procedure, cost will be borne by the patient.
9. Loss or theft of dentures or bridgework.
10. Any procedure of implantation or of experimental procedures.
11. General anesthesia (except for oral surgery).
12. Services that cannot be performed because of the general health of the patient.
13. Services which are reimbursable by insurance or reimbursable under any other group or health service plans. The Plan shall provide the services at the time of need, but the Member shall execute such documents necessary to assure that the Plan is reimbursed for such benefits.
14. Fees incurred for broken or missed appointments (without 12 hours notice) are the Member's responsibility.
15. Prophylaxis - once every six months.
16. Fluoride treatment - two per year to age 18.
17. Denture relines are limited to two per year.

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EXHIBIT 2

HN GEMINI DHMO 50-S

LIMITATION OF BENEFITS

Listed below are limitations on services covered under the plan.

1. Prophylaxis is limited to one every six consecutive months.
2. Fluoride treatment is a covered benefit up to the eighteenth birthday, once every twelve months.
3. Bitewing x-rays are limited to one series of four films in any twelve consecutive months.
4. Full mouth x-rays are limited to once every twenty-four consecutive months.
5. Sealants are covered up to the fourteenth birthday and are limited to permanent first and second molars only.
6. Periodontal treatments (gingival curettage and root planing) are limited to four separate quadrants in any twelve consecutive months and no more than two quadrants per date of service.
7. Periodontal maintenance procedure/ periodontal prophylaxis (including minor scaling) is limited to one time per six consecutive months following scaling and root planing (active therapy).
8. Periodontal surgery (gingivectomy or osseous mucogingival) is limited to once per quadrant in any thirty-six consecutive months.
9. A full or removable partial, upper/lower denture is not to exceed one each in any five-year period, and only if it is unsatisfactory and cannot be made satisfactory by either reline or repair.
10. Replacement of a restoration is covered only when it is Dentally Necessary.
11. Fixed partial dentures will be covered only when a removable partial denture cannot satisfactorily restore the case. If fixed partial dentures are used when a removable partial denture could satisfactorily restore the case, then the fixed partial denture is considered to be Optional Treatment.
12. Full cast crowns, porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. The Plan covers an acrylic or stainless steel crown.
13. A crown placed on a specific tooth is covered only once in any five-year period and only if it cannot be repaired and restored to natural function. A maximum of five units of crown and removable partial dentures will be covered in any one arch, in accordance with the Plan's policies and procedures.
14. Crown lengthening, in lieu of all other restorative treatment performed on the same tooth on the same day, is limited to one time per tooth per lifetime.
15. Relining or rebasing of complete or immediate dentures, as Dentally Necessary, within six months of installation of the replacement denture is limited to one. After the initial six months, relining and rebasing is limited to one per arch per year at the applicable copayment.
16. Pedodontic referral for children up to the sixth birthday will be covered only after two attempts for treatment have been made by the Primary Dentist.
17. Specialty referral benefits are limited to necessary endodontic, periodontic and oral surgery procedures that cannot be rendered by the assigned Primary Dentist.
18. Consultation by a specialist for non-Covered Services is excluded.
19. Stayplates are only a benefit to replace extracted anterior teeth for adults.
20. Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other service (except x-rays) are rendered during the visit.
21. Notwithstanding anything to the contrary that may be contained in the Evidence of Coverage, you will be reimbursed for all covered services which are deemed necessary emergency dental care.

EXHIBIT 2

HN GEMINI DHMO 50-S

EXCLUSION OF BENEFITS

Listed below are those services or expenses NOT covered under the plan that become the responsibility of the member at the Dentist's Usual and Customary fee.

1. Services to which the Member is entitled under any Worker's Compensation Law or Act or any other insurance plan, even if the Member did not claim those benefits.
2. Procedures that are: (a) not Dentally Necessary; or are (b) not customarily recognized throughout the dentist's field of specialty as essential for the treatment of the condition; c) for services that are not prescribed by the attending Participating Dentist.
3. Temporomandibular joint treatment (T.M.J.).
4. Elective or cosmetic dentistry, except as listed in the Benefit Schedule as a Covered Service and performed by a Participating Dentist. Benefits for resin-based composite restorations on posterior teeth (behind the second bicuspid) will be based on the allowance for the corresponding amalgam restoration.
5. Oral surgery requiring the setting of fractures or dislocations. Orthognathic surgery or other oral surgical procedures solely for orthodontic purposes.
6. Loss or theft of full or partial dentures or other dental appliances.
7. Services including: (a) broken appointments; (b) dispensing of drugs; (c) diagnostic photographs; (d) panoramic x-ray, except when used as a part of a full mouth series in the Participating Primary Dentist office only; (e) athletic mouthguards; (f) precision or semi-precision attachments; (g) denture duplication; (h) harmful habit appliances; (i) congenital or developmental malformations, including, but not limited to cleft palate, (i) congenital or developmental malformations, including, but not limited to cleft palate, congenitally missing or supernumerary teeth; (j) a service not specifically palate, congenitally missing or supernumerary teeth; (j) a service not specifically listed as a covered benefit; (k) x-rays rendered at a specialist's office (except for authorized pedodontic referrals); (l) hospital charges of any kind.
8. Oral surgical procedures involving: (a) recontouring of hard and soft tissues; (b) sinus exploration; (c) oral antral fistulas; (d) removal of foreign bodies; (e) salivary glands and ducts; (f) the removal or treatment of cysts, tumors, or neoplasms.
9. Any procedure of implantation, reimplantation or related procedures.
10. Procedures that are considered Experimental or investigative or that are not widely accepted as proven and effective within the organized dental community.
11. General anesthesia, inhalation sedation, intravenous sedation, oral sedation drugs or intramuscular sedation.
12. Treatment or consultations rendered by a specialist if: (a) a Member is deemed unmanageable for treatment by the Primary Dentist, except for children up to the sixth birthdate; or (b) treatment cannot be rendered by the Primary Dentist due to the medical condition or physical limitations of the Member; or c) a consultation is for non-Covered Services.
13. Dental expenses incurred under this dental plan that are in connection with any dental procedure started prior to the Member's effective date under this Plan or after termination of the Member's coverage.
14. Procedures relating to: (a) bite analysis; (b) the correction of abrasion, erosion, or attrition; (c) the change of contact or contour; (d) restorations for the purpose or attrition; (c) the change of contact or contour; (d) restorations for the of splinting (except when necessary in conjunction with periodontal treatment); (e) grafting; (f) the treatment of non-pathologic conditions; and (g) overdentures and associated procedures.
15. Services that, in the opinion of the Plan, do not have a reasonable, favorable prognosis.
16. Disease contracted or injuries sustained as a result of a major disaster, war, declared or undeclared, epidemic conditions or from exposure to nuclear energy, whether or not a result of war.
17. Further liability for additional treatment on a tooth when the Member and provider have elected a treatment plan that is disallowed by the Plan.
18. Crowns, inlays or onlays for teeth that can be satisfactorily restored by other means that meet professionally recognized standards.
19. All crowns and fixed or removable partial dentures for full mouth reconstruction, defined as treatment relating to: (a) the charge of vertical dimension, or defined as treatment relating to: (a) the change of vertical dimension, or (b) the restoration of occlusion, or c) extensive restorative treatment involving all remaining occluding teeth.
20. A Participating Dentist may refuse treatment to any Member who continually fails to follow a prescribed course of treatment.

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**HEALTH NET OF CA / CENTENE DHMO
LIMITATIONS AND EXCLUSIONS OF BENEFITS
EXHIBIT 2**



**HN IFP DHMO Adult Buy Up
LIMITATIONS & EXCLUSIONS OF BENEFITS**

1. Initial prophylaxis is limited to one every 12 months. "Second Prophylaxis" is limited to one every 12 months.
2. Fluoride treatment is covered twice in any 12 month period.
3. Bitewing x-rays are limited to one series of four films in any 12 month period.
4. Full mouth x-rays are limited to once every 36 months or as needed consistent with professional practice guidelines.
5. Periodontal treatments (sub-gingival curettage and root planing) are limited to five in any 12 month period.
6. Replacement of a restoration is covered only when it is Dentally Necessary.
7. Fixed bridgework will be covered only when partial bridgework cannot satisfactorily restore the case.
8. Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
9. Partial dentures will be replaced as dentally necessary consistent with professional standards of practice.
10. Full upper and/or lower dentures will be replaced as dentally necessary consistent with professional standards of practice.
11. The following services, if in the opinion of the attending dentist or Health net are not Dentally Necessary, will not be covered:
 - Temporomandibular joint treatment (aka "TMJ").
 - Elective Dentistry and cosmetic dentistry.
 - Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
 - Treatment of malignancies, cysts, neoplasms or congenital malformations.
 - Prescription Medications.
 - Hospital charges of any kind.
 - Loss or theft of full or partial dentures.
 - Any procedure of implantation.
 - Any Experimental procedure. Experimental treatment if denied may be appealed through the Independent Medical Review process and that service shall be covered and provided if required under the Independent Medical Review process.
 - General anesthesia or Intravenous/Conscious sedation, except as specified in the medical benefits portion of this Plan Contract and EOC.
 - Services that cannot be performed because of the physical or behavioral limitations of the patient.
 - Fees incurred for broken or missed appointments (without 24 hours' notice) are the Member's responsibility. However, the Copayment for missed appointments may not apply if: (1) the Member canceled at least 24 hours in advance; or (2) the Member missed the appointment because of an emergency or circumstances beyond the control of the Member.
 - Any procedure performed for the purpose of correcting contour, contact or occlusion.
 - Any procedure that is not specifically listed as a Covered Service.

**HEALTH NET OF CA / CENTENE DHMO
LIMITATIONS AND EXCLUSIONS OF BENEFITS
EXHIBIT 2**



**HN IFP DHMO Adult Buy Up
LIMITATIONS & EXCLUSIONS OF BENEFITS**

12. Dental services or supplies are limited to the following situations:
- When immediate emergency care to sound natural teeth as a result of an accidental injury is required.
 - General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Member requires that an ordinarily non-covered dental service which would normally be treated in the dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services, must be Medically Necessary and are subject to the other exclusions and limitations of this Plan Contract and will only be covered under the following circumstances: (a) Members who are under seven years of age, or (b) Members who are developmentally disabled, or (c) Members whose health is compromised and general anesthesia is Medically Necessary.
 - When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.
 - Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
13. The following services are not covered under any circumstances:
- Routine care or treatment of teeth and gums including but not limited to dental abscesses, inflamed tissue or extraction of teeth.
 - Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints or Orthotics (whether custom fit or not), or other dental appliances, and related surgeries to treat dental conditions.
 - Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants.
- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury regardless of reason for such services.

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**HEALTH NET OF CA / CENTENE DHMO
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**



EXHIBIT 2 - PART IV

CDT CODE	Plan Name: Agreement ID:	HN Buy Up Group / HN DHMO Group Med Supp Buy Up	HN DHMO Medicare Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp	HN Custom CV DHMO Grp Ret	Boeing DHMO Buy Up Group
		SCFG00000207	SCFG00000208	SCFG00000211	SCFG00000219
CDT codes not listed are not a covered benefit / NTCV = Not Covered		Medicare	Medicare	Commercial	Medicare
MINIMUM GUARANTEE:		NO	NO	NO	NO
SPECIALTY REFERRAL:		DIRECT	DIRECT	DIRECT	DIRECT
I. DIAGNOSTIC					
D0120	periodic oral evaluation – established patient	0	0	0	0
D0140	limited oral evaluation – problem focused	0	0	NTCV	0
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0	0	NTCV	NTCV
D0150	comprehensive oral evaluation – new or established patient	0	0	NTCV	0
D0160	detailed and extensive oral evaluation – problem focused, by report	0	0	NTCV	NTCV
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)	0	0	NTCV	NTCV
D0171	re-evaluation – post-operative office visit	NTCV	0	NTCV	NTCV
D0180	comprehensive periodontal evaluation – new or established patient	0	0	NTCV	NTCV
D0190	screening of a patient	NTCV	0	NTCV	NTCV
D0191	assessment of a patient	NTCV	0	NTCV	NTCV
D0210	intraoral – complete series of radiographic images	0	0	0	0
D0220	intraoral – periapical first radiographic image	0	0	0	0
D0230	intraoral – periapical each additional radiographic image	0	0	0	0
D0240	intraoral – occlusal radiographic image	0	0	NTCV	NTCV
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0	0	NTCV	NTCV
D0251	extra-oral posterior dental radiographic image	NTCV	0	NTCV	NTCV
D0270	bitewing – single radiographic image	0	0	NTCV	NTCV
D0272	bitewings – two radiographic images	0	0	0	0
D0273	bitewings – three radiographic images	0	0	NTCV	NTCV
D0274	bitewings – four radiographic images	0	0	0	0
D0277	vertical bitewings – 7 to 8 radiographic images	NTCV	0	NTCV	NTCV
D0330	panoramic radiographic image	0	0	NTCV	NTCV
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0	0	NTCV	NTCV
D0351	3D photographic image	NTCV	0	NTCV	NTCV
D0411	HbA1c in-office point of service testing	NTCV	0	NTCV	NTCV
D0417	collection and preparation of saliva sample for laboratory diagnostic testing	NTCV	0	NTCV	NTCV
D0418	analysis of saliva sample	0	0	0	0
D0460	pulp vitality tests	0	0	NTCV	NTCV

**HEALTH NET OF CA / CENTENE DHMO
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**



EXHIBIT 2 - PART IV

CDT CODE	Plan Name: Agreement ID:	HN Buy Up Group / HN DHMO Group Med Supp Buy Up SCFG00000207	HN DHMO Medicare	HN Custom CV DHMO Grp Ret SCFG00000211	Boeing DHMO Buy Up Group SCFG00000219
			Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp SCFG00000208		
D0470	diagnostic casts	NTCV	15	NTCV	NTCV
D0472	accession of tissue, gross examination, preparation and transmission of written report	0	0	NTCV	NTCV
D0473	accession of tissue, gross and microscopic examination, preparation and transmission of written report	0	0	NTCV	NTCV
D0474	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	0	0	NTCV	NTCV
D0486	laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.	0	0	NTCV	NTCV
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	NTCV	0	NTCV	NTCV
D0601	caries risk assessment and documentation, with a finding of low risk	0	NTCV	0	0
D0602	caries risk assessment and documentation, with a finding of moderate risk	0	NTCV	0	0
D0603	caries risk assessment and documentation, with a finding of high risk	0	NTCV	0	0
	office visit - per visit (includes all fees for sterilization and/or infection control)	Not Applicable	0	Not Applicable	Not Applicable
II. PREVENTIVE					
† In addition to one allowed every six months / *One additional prophylaxis per year					
D1110	prophylaxis – adult	0	0	0	0
D1110	prophylaxis – adult - additional	25*	40†	25*	0*
D1120	prophylaxis – child	0	0	0	0
D1120	prophylaxis – child - additional	25*	25†	25*	0*
D1206	topical application of fluoride varnish	0	0	NTCV	NTCV
D1208	topical application of fluoride – excluding varnish	0	0	0	0
D1310	nutritional counseling for control of dental disease	0	0	NTCV	NTCV
D1330	oral hygiene instructions	0	0	0	0
D1351	sealant – per tooth	10	12	10	10
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth	10	NTCV	10	10
D1353	sealant repair – per tooth	10	12	10	10
D1354	interim caries arresting medicament application - per tooth	NTCV	15	NTCV	NTCV
D1510	space maintainer – fixed, unilateral	60	55	60	60
D1516	space maintainer – fixed – bilateral, maxillary	NTCV	55	NTCV	NTCV
D1517	space maintainer – fixed – bilateral, mandibular	NTCV	55	NTCV	NTCV
D1520	space maintainer – removable – unilateral	NTCV	55	NTCV	NTCV

HEALTH NET OF CA / CENTENE DHMO
PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS



EXHIBIT 2 - PART IV

CDT CODE	Plan Name: Agreement ID:	HN Buy Up Group / HN DHMO Group Med Supp Buy Up	HN DHMO Medicare Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp	HN Custom CV DHMO Grp Ret	Boeing DHMO Buy Up Group
		SCFG00000207	SCFG00000208	SCFG00000211	SCFG00000219
D1526	space maintainer – removable – bilateral, maxillary	NTCV	55	NTCV	NTCV
D1527	space maintainer – removable – bilateral, mandibular	NTCV	55	NTCV	NTCV
D1550	re-cement or re-bond space maintainer	NTCV	10	NTCV	NTCV
D1555	removal of fixed space maintainer	NTCV	10	NTCV	NTCV
D1575	distal shoe space maintainer – fixed – unilateral	60	55	60	60
III. RESTORATIVE					
<ul style="list-style-type: none"> • Dental copayments have an additional charge not to exceed the actual lab cost for noble and high noble metals. • Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional \$125 copayment per unit in addition to the copayment for each crown/bridge unit. (Applicable to the Buy Up Group, DHMO Group, Med Supp Buy Up, HN Custom CV DHMO Grp Ret, and Boeing DHMO Buy Up Group) • Resin and porcelain materials are excluded for molars. (Applicable to the Buy Up Group, DHMO Group, Med Supp Buy Up, HN Custom CV DHMO Grp Ret, and Boeing DHMO Buy Up Group) 					
† Copayments reflect primary versus permanent tooth copayment.					
D2140	amalgam – one surface, primary or permanent	20/25†	10/18†	20/25†	20/25†
D2150	amalgam – two surfaces, primary or permanent	25/30†	12/20†	25/30†	25/30†
D2160	amalgam – three surfaces, primary or permanent	30/30†	16/22†	30/30†	30/30†
D2161	amalgam – four or more surfaces, primary or permanent	35/45†	24/27†	35/40†	35/45†
D2330	resin-based composite – one surface, anterior	50	20	50	50
D2331	resin-based composite – two surfaces, anterior	60	24	60	60
D2332	resin-based composite – three surfaces, anterior	60	40	60	60
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)	60	50	60	60
D2390	resin-based composite crown, anterior	NTCV	50	NTCV	NTCV
D2391	resin-based composite – one surface, posterior	NTCV	45/80†	NTCV	NTCV
D2392	resin-based composite – two surfaces, posterior	NTCV	45/85†	NTCV	NTCV
D2393	resin-based composite – three surfaces, posterior	NTCV	55/90†	NTCV	NTCV
D2394	resin-based composite – four or more surfaces, posterior	NTCV	60/100†	NTCV	NTCV
D2510	inlay – metallic – one surface	NTCV	225	NTCV	NTCV
D2520	inlay – metallic – two surfaces	NTCV	225	NTCV	NTCV
D2530	inlay – metallic – three or more surfaces	NTCV	225	NTCV	NTCV
D2542	onlay – metallic – two surfaces	NTCV	225	NTCV	NTCV
D2543	onlay – metallic – three surfaces	NTCV	225	NTCV	NTCV
D2544	onlay – metallic – four or more surfaces	NTCV	225	NTCV	NTCV
D2710	crown – resin-based composite (indirect)	120	NTCV	120	120
D2712	crown – ¾ resin-based composite (indirect)	240	NTCV	240	240
D2720	crown – resin with high noble metal	170	NTCV	170	170
D2721	crown – resin with predominantly base metal	170	NTCV	170	170

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D2722	crown – resin with noble metal	170	NTCV	170	170
D2740	crown – porcelain/ceramic	210	300	210	210
D2750	crown – porcelain fused to high noble metal	240	225	240	240
D2751	crown – porcelain fused to predominantly base metal	260	225	260	260
D2752	crown – porcelain fused to noble metal	260	225	260	260
D2780	crown – ¾ cast high noble metal	NTCV	225	NTCV	NTCV
D2781	crown – ¾ cast predominantly base metal	NTCV	225	NTCV	NTCV
D2782	crown – ¾ cast noble metal	NTCV	225	NTCV	NTCV
D2783	crown – ¾ porcelain/ceramic	NTCV	225	NTCV	NTCV
D2790	crown – full cast high noble metal	240	225	240	240
D2791	crown – full cast predominantly base metal	240	225	240	240
D2792	crown – full cast noble metal	240	225	240	240
D2794	crown – titanium	240	225	240	240
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	NTCV	10	NTCV	NTCV
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	15	10	15	15
D2920	re-cement or re-bond crown	15	10	15	15
D2921	reattachment of tooth fragment, incisal edge or cusp	6	NTCV	6	6
D2930	prefabricated stainless steel crown – primary tooth	50	25	50	50
D2931	prefabricated stainless steel crown – permanent tooth	50	35	50	50
D2940	protective restoration	15	0	15	15
D2941	interim therapeutic restoration – primary dentition	15	NTCV	15	15
D2950	core buildup, including any pins when required	20	30	20	20
D2951	pin retention – per tooth, in addition to restoration	20	15	20	20
D2952	post and core in addition to crown, indirectly fabricated	80	75	80	80
D2953	each additional indirectly fabricated post – same tooth	NTCV	40	NTCV	NTCV
D2954	prefabricated post and core in addition to crown	40	55	40	40
D2955	post removal	NTCV	10	NTCV	NTCV
D2980	crown repair necessitated by restorative material failure	6	NTCV	6	6
D2981	inlay repair necessitated by restorative material failure	6	NTCV	6	6
D2982	onlay repair necessitated by restorative material failure	6	NTCV	6	6
D2983	veneer repair necessitated by restorative material failure	NTCV	NTCV	NTCV	NTCV
D2990	resin infiltration of incipient smooth surface lesions	10	NTCV	10	10

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IV. ENDODONTICS

‡ First listed copayment is applied to the General Dentist. Second listed copayment is applied to the Specialist (Endodontist, Oral Surgeon or Periodontist).

D3110	pulp cap – direct (excluding final restoration)	10/38‡	5	10/38‡	10/38‡
D3120	pulp cap – indirect (excluding final restoration)	10/47‡	5	10/47‡	10/47‡
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	40/71‡	18	40/71‡	40/71‡
D3221	pulpal debridement, primary and permanent teeth	NTCV	18	NTCV	NTCV
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	NTCV	NTCV	40/71‡	NTCV
D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	NTCV	25	NTCV	NTCV
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	NTCV	25	NTCV	NTCV
D3310	endodontic therapy, anterior tooth (excluding final restoration)	140/336‡	85	140/336‡	140/336‡
D3320	endodontic therapy, premolar tooth (excluding final restoration)	160/398‡	145	160/398‡	160/398‡
D3330	endodontic therapy, molar tooth (excluding final restoration)	230/517‡	225	230/517‡	230/517‡
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	140/336‡	85	140/336‡	140/336‡
D3346	retreatment of previous root canal therapy – anterior	NTCV	170	NTCV	NTCV
D3347	retreatment of previous root canal therapy – premolar	NTCV	245	NTCV	NTCV
D3348	retreatment of previous root canal therapy – molar	0	275	NTCV	NTCV
D3351	apexification/recalcification – initial visit (apical closure/calific repair of perforations, root resorption, etc.)	20/113‡	65	20/113‡	20/113‡
D3352	apexification/recalcification – interim medication replacement	NTCV	65	NTCV	NTCV
D3353	apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calific repair of perforations, root resorption, etc.)	NTCV	65	NTCV	NTCV
D3355	Pulpal regeneration - initial visit	20	NTCV	20	20
D3410	apicoectomy – anterior	100/383‡	125	100/383‡	100/383‡
D3421	apicoectomy – premolar (first root)	100/448‡	150	100/448‡	100/448‡
D3425	apicoectomy – molar (first root)	100/562‡	160	100/562‡	100/562‡
D3426	apicoectomy (each additional root)	NTCV	125	NTCV	NTCV
D3430	retrograde filling – per root	NTCV	95	NTCV	NTCV
D3450	root amputation – per root	NTCV	150	NTCV	NTCV
D3920	hemisection (including any root removal), not including root canal therapy	NTCV	125	NTCV	NTCV

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Agreement ID:		SCFG00000207	SCFG00000208	SCFG00000211	SCFG00000219

V. PERIODONTICS - Includes periodontal charting for planning treatment of periodontal disease and periodontal hygiene instruction

‡ First listed copayment is applied to the General Dentist. Second listed copayment is applied to the Specialist (Endodontist, Oral Surgeon or Periodontist).

D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	130/257‡	100	130/257‡	130/257‡
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	25/82‡	35	25/82‡	25/82‡
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	150/265‡	275	150/265‡	150/265‡
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	30/88‡	275	30/88‡	30/88‡
D4249	clinical crown lengthening – hard tissue	NTCV	160	NTCV	NTCV
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	160/591‡	350	160/591‡	160/591‡
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	100/300‡	350	100/300‡	100/300‡
D4270	pedicle soft tissue graft procedure	NTCV	375	NTCV	NTCV
D4273	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position	NTCV	375	NTCV	NTCV
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	NTCV	50	NTCV	NTCV
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	NTCV	NTCV	NTCV	NTCV
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	NTCV	375	NTCV	NTCV
D4341	periodontal scaling and root planing – four or more teeth per quadrant	35/108‡	40	35/108‡	35/108‡
D4342	periodontal scaling and root planing – one to three teeth per quadrant	14/85‡	40	14/85‡	14/85‡
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full	NTCV	35	NTCV	NTCV
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	10/68‡	40	10/68‡	10/68‡
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	NTCV	60	NTCV	NTCV
D4910	periodontal maintenance	NTCV	35	NTCV	NTCV
D4921	gingival irrigation - per quadrant	0	NTCV	0	0

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VI. PROSTHODONTICS (REMOVABLE)

¹ Includes up to 3 adjustments within 60 days of delivery.

² First tooth \$50 copayment; Each additional tooth \$15 copayment; and additional copayment - per unit - teeth and clasps \$20.

³ \$30 copayment for the first tooth and \$15 for each additional tooth.

⁴ Copayment is applicable to first two teeth. Each additional tooth copayment is \$15.

D5110	complete denture – maxillary	320 ¹	200	320 ¹	320 ¹
D5120	complete denture – mandibular	320 ¹	200	320 ¹	320 ¹
D5130	immediate denture – maxillary	NTCV	200	NTCV	NTCV
D5140	immediate denture – mandibular	NTCV	200	NTCV	NTCV
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and	240 ¹	200	240 ¹	240 ¹
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and	240 ¹	225	240 ¹	240 ¹
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	320 ¹	250	320 ¹	320 ¹
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	320 ¹	250	320 ¹	320 ¹
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	130	70	130	130
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	130	70	130	130
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	130	70	130	130
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	130	70	130	130
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	NTCV	NTCV	120	NTCV
D5283	removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	NTCV	NTCV	120	NTCV
D5410	adjust complete denture – maxillary	20	15	20	20
D5411	adjust complete denture – mandibular	20	15	20	20
D5421	adjust partial denture – maxillary	20	15	20	20
D5422	adjust partial denture – mandibular	20	15	20	20
D5511	repair broken complete denture base, mandibular	20	15	20	20
D5512	repair broken complete denture base, maxillary	20	15	20	20
D5611	repair resin partial denture base, mandibular	20	15	20	20

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D5612	repair resin partial denture base, maxillary	20	15	20	20
D5621	repair cast partial framework, mandibular	20	15	20	20
D5622	repair cast partial framework, maxillary	20	15	20	20
D5630	repair or replace broken clasp – per tooth	25	30	25	25
D5640	replace broken teeth – per tooth	50 ²	35	50 ²	50 ²
D5650	add tooth to existing partial denture	30 ³	35	30 ³	30 ³
D5660	add clasp to existing partial denture – per tooth	20	35	20	20
D5710	rebase complete maxillary denture	NTCV	100	NTCV	NTCV
D5711	rebase complete mandibular denture	NTCV	100	NTCV	NTCV
D5720	rebase maxillary partial denture	NTCV	100	NTCV	NTCV
D5721	rebase mandibular partial denture	NTCV	100	NTCV	NTCV
D5730	reline complete maxillary denture (chairside)	40	45	40	40
D5731	reline complete mandibular denture (chairside)	40	45	40	40
D5740	reline maxillary partial denture (chairside)	40	45	40	40
D5741	reline mandibular partial denture (chairside)	40	45	40	40
D5750	reline complete maxillary denture (laboratory)	130	70	130	130
D5751	reline complete mandibular denture (laboratory)	130	70	130	130
D5760	reline maxillary partial denture (laboratory)	130	70	130	130
D5761	reline mandibular partial denture (laboratory)	130	70	130	130
D5810	interim complete denture (maxillary)	NTCV	100	NTCV	NTCV
D5811	interim complete denture (mandibular)	NTCV	100	NTCV	NTCV
D5820	interim partial denture (maxillary)	130 ⁴	70	130 ⁴	130 ⁴
D5821	interim partial denture (mandibular)	130 ⁴	70	130 ⁴	130 ⁴
D5850	tissue conditioning, maxillary	25	25	25	25
D5851	tissue conditioning, mandibular	25	25	25	25
D5863	overdenture - complete maxillary	320	NTCV	320	320
D5864	overdenture - complete mandibular	320	NTCV	320	320
D5865	overdenture - partial maxillary	320	NTCV	320	320
D5866	overdenture - partial mandibular	320	NTCV	320	320
D5876	add metal substructure to acrylic full denture (per arch)	NTCV	100	NTCV	NTCV

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IX. PROSTHODONTICS, FIXED

- Dental copayments have an additional charge not to exceed the actual lab cost for noble and high noble metals.

† Resin and porcelain materials are excluded for molars.

D6210	pontic – cast high noble metal	230	225	230	230
D6211	pontic – cast predominantly base metal	230	225	230	230
D6212	pontic – cast noble metal	230	225	230	230
D6214	pontic – titanium	240	225	240	240
D6240	pontic – porcelain fused to high noble metal	260†	225	260†	260†
D6241	pontic – porcelain fused to predominantly base metal	260†	225	260†	260†
D6242	pontic – porcelain fused to noble metal	260†	225	260†	260†
D6245	pontic – porcelain/ceramic	210†	225	210†	210†
D6250	pontic – resin with high noble metal	170	NTCV	170†	170†
D6251	pontic – resin with predominantly base metal	170	NTCV	170†	170†
D6252	pontic – resin with noble metal	170	NTCV	170†	170†
D6545	retainer – cast metal for resin bonded fixed prosthesis	120	NTCV	120	120
D6549	resin retainer – for resin bonded fixed prosthesis	120	NTCV	120	120
D6710	retainer crown – indirect resin based composite	240	NTCV	240†	240†
D6720	retainer crown – resin with high noble metal	170	NTCV	170†	170†
D6721	retainer crown – resin with predominantly base metal	170	NTCV	170†	170†
D6722	retainer crown – resin with noble metal	170	NTCV	170†	170†
D6750	retainer crown – porcelain fused to high noble metal	260†	225	260†	260†
D6751	retainer crown – porcelain fused to predominantly base metal	177†	225	177†	177†
D6752	retainer crown – porcelain fused to noble metal	260†	225	260†	260†
D6780	retainer crown – ¾ cast high noble metal	240	225	240	240
D6781	retainer crown – ¾ cast predominantly base metal	240	225	240	240
D6782	retainer crown – ¾ cast noble metal	240	225	240	240
D6790	retainer crown – full cast high noble metal	240	225	240	240
D6791	retainer crown – full cast predominantly base metal	240	225	240	240
D6792	retainer crown – full cast noble metal	240	225	240	240
D6794	retainer crown – titanium	240	225	240	240
D6930	re-cement or re-bond fixed partial denture	6	0	6	6
D6940	stress breaker	50	NTCV	50	50

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		SCFG00000207	SCFG00000208		

X. ORAL AND MAXILLOFACIAL SURGERY - includes routine post operative treatment.

‡ First listed copayment is applied to the General Dentist. Second listed copayment is applied to the Specialist (Endodontist, Oral Surgeon or Periodontist).

D7111	extraction, coronal remnants – primary tooth	35	15	35	35
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	25/75‡	15	25/75‡	25/75‡
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	40/128‡	40	40/128‡	40/128‡
D7220	removal of impacted tooth – soft tissue	60/154‡	60	60/154‡	60/154‡
D7230	removal of impacted tooth – partially bony	80/195‡	80	80/195‡	80/195‡
D7240	removal of impacted tooth – completely bony	110/223‡	125	110/223‡	110/223‡
D7241	removal of impacted tooth – completely bony, with unusual surgical complications	NTCV	150	NTCV	NTCV
D7250	removal of residual tooth roots (cutting procedure)	NTCV	50	NTCV	NTCV
D7251	coronectomy – intentional partial tooth removal	NTCV	50	NTCV	NTCV
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	NTCV	110	NTCV	NTCV
D7280	exposure of an unerupted tooth	NTCV	175	NTCV	NTCV
D7285	incisional biopsy of oral tissue – hard (bone, tooth)	NTCV	60	NTCV	NTCV
D7286	incisional biopsy of oral tissue – soft	NTCV	60	NTCV	NTCV
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	NTCV	55	NTCV	NTCV
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	NTCV	18	NTCV	NTCV
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	NTCV	70	NTCV	NTCV
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	NTCV	23	NTCV	NTCV
D7510	incision and drainage of abscess – intraoral soft tissue	25/86‡	0	25/86‡	25/86‡
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes	25/86‡	0	25/86‡	25/86‡
D7881	occlusal orthotic device adjustment	20	15	20	20
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	NTCV	45	NTCV	NTCV
D7963	frenuloplasty	NTCV	45	NTCV	NTCV
D7971	excision of pericoronal gingiva	NTCV	60	NTCV	NTCV

XII. ADJUNCTIVE GENERAL SERVICES

D9110	palliative (emergency) treatment of dental pain – minor procedure	25	0	25	25
D9120	fixed partial denture sectioning	0	0	NTCV	NTCV
D9210	local anesthesia not in conjunction with operative or surgical procedures	0	0	NTCV	NTCV

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D9211	regional block anesthesia	0	0	NTCV	NTCV
D9212	trigeminal division block anesthesia	NTCV	NTCV	NTCV	NTCV
D9215	local anesthesia in conjunction with operative or surgical procedures	0	0	0	0
D9219	evaluation for deep sedation or general anesthesia	NTCV	0	NTCV	NTCV
D9222	deep sedation/general anesthesia – first 15 minutes	NTCV	60	NTCV	NTCV
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment	NTCV	60	NTCV	NTCV
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	NTCV	60	NTCV	NTCV
D9243	intravenous moderate (conscious) sedation/anesthesia – each subsequent 15 minute	NTCV	60	NTCV	NTCV
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	NTCV	0	NTCV	NTCV
D9311	consultation with a medical health care professional	NTCV	0	NTCV	NTCV
D9430	office visit for observation (during regularly scheduled hours) – no other services performed	NTCV	0	NTCV	NTCV
D9440	office visit – after regularly scheduled hours	40	20	40	40
D9630	drugs or medicaments dispensed in the office for home use	NTCV	15	NTCV	NTCV
D9910	application of desensitizing medicament	NTCV	15	NTCV	NTCV
D9942	repair and/or reline of occlusal guard	NTCV	45	NTCV	NTCV
D9943	occlusal guard adjustment	20	15	20	20
D9944	occlusal guard – hard appliance, full arch	100	100	NTCV	NTCV
D9945	occlusal guard – soft appliance, full arch	100	100	NTCV	NTCV
D9946	occlusal guard – hard appliance, partial arch	50	50	NTCV	NTCV
D9951	occlusal adjustment – limited	0	0	NTCV	NTCV
D9952	occlusal adjustment – complete	NTCV	75	NTCV	NTCV
D9995	teledentistry – synchronous; real-time encounter	NTCV	0	NTCV	0
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	NTCV	0	NTCV	0
	record transfer - transfer of all materials with or without an x-ray(s)	NTCV	15	NTCV	NTCV
COSMETIC DENTISTRY SERVICES (ELECTIVE SERVICES)					
D2330	resin-based composite – one surface, anterior	Not Applicable	80	Not Applicable	Not Applicable
D2331	resin-based composite – two surfaces, anterior	Not Applicable	95	Not Applicable	Not Applicable
D2332	resin-based composite – three surfaces, anterior	Not Applicable	105	Not Applicable	Not Applicable
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)	Not Applicable	125	Not Applicable	Not Applicable
D2391	resin-based composite – one surface, posterior	Not Applicable	85	Not Applicable	Not Applicable
D2392	resin-based composite – two surfaces, posterior	Not Applicable	100	Not Applicable	Not Applicable
D2393	resin-based composite – three surfaces, posterior	Not Applicable	110	Not Applicable	Not Applicable

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EXHIBIT 2 - PART IV

CDT CODE	Plan Name: Agreement ID:	HN Buy Up Group / HN DHMO Group Med Supp Buy Up SCFG00000207	HN DHMO Medicare	HN Custom CV DHMO Grp Ret SCFG00000211	Boeing DHMO Buy Up Group SCFG00000219
			Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp SCFG00000208		
D2394	resin-based composite – four or more surfaces, posterior	Not Applicable	130	Not Applicable	Not Applicable
D2740	crown – porcelain/ceramic (leucite-reinforced pressed crown/empress manufacturer)	Not Applicable	700	Not Applicable	Not Applicable
D2962	labial veneer (porcelain laminate) – laboratory	Not Applicable	450	Not Applicable	Not Applicable
D5110	complete denture – maxillary (comfort flex acetyl resin homopolymer)	Not Applicable	650	Not Applicable	Not Applicable
D5120	complete denture – mandibular (comfort flex acetyl resin homopolymer)	Not Applicable	650	Not Applicable	Not Applicable
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth) - comfort flex acetyl resin homopolymer	Not Applicable	725	Not Applicable	Not Applicable
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth) - comfort flex acetyl resin homopolymer	Not Applicable	725	Not Applicable	Not Applicable
D9972	external bleaching – per arch – performed in office	Not Applicable	125	Not Applicable	Not Applicable
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays	Not Applicable	125	Not Applicable	Not Applicable

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**HEALTH NET OF CA DHMO
LIMITATIONS AND EXCLUSIONS OF BENEFITS
EXHIBIT 2**



HN Medicare Supp Buy Up Farm Bureau, HN DHMO Medicare Supp Buy Up, HN SNP RMC DHMO Supp, HN Medicare Supp Buy Up Ruby, HN DHMO Medicare Supp Buy Up Salud & HN SNP RMC DHMO Supp

LIMITATION OF BENEFITS

Listed below are limitations on services covered under the plan.

1. Prophylaxis is limited to two per 12 months at no charge. Additional prophylaxis services will be at a copayment of \$40 for adults (age 18 and older) and \$25 for children (age 17 and under).
2. Fluoride treatment is limited to once every twelve months for adults (age 18 and older) and children (age 17 and under).
3. Bitewing x-rays are limited to one series of four films in any twelve consecutive months.
4. Full mouth x-rays are limited to once every twenty-four consecutive months.
5. Sealants are covered up to the fourteenth birthdate and are limited to permanent first and second molars only.
6. Periodontal treatments (gingival curettage and root planing) are limited to four separate quadrants in any twelve consecutive months and no more than two quadrants per date of service.
7. Periodontal maintenance procedure/ periodontal prophylaxis (including minor scaling) is limited to two per 12 consecutive months following scaling and root planing (active therapy).
8. Periodontal surgery (gingivectomy or osseous mucogingival) is limited to once per quadrant in any thirty-six consecutive months.
9. A full or removable partial, upper/lower denture is not to exceed one each in any five-year period, and only if it is unsatisfactory and cannot be made satisfactory by either reline or repair.
10. Replacement of a restoration is covered only when it is Dentally Necessary.
11. Fixed partial dentures will be covered only when a removable partial denture cannot satisfactorily restore the case. If fixed partial dentures are used when a removable partial denture could satisfactorily restore the case, then the fixed partial denture is considered to be Optional Treatment.
12. Full cast crowns, porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. The Plan covers an acrylic or stainless steel crown.
13. A crown placed on a specific tooth is covered only once in any five-year period and only if it cannot be repaired and restored to natural function. A maximum of five units of crown and removable partial dentures will be covered in any one arch.
14. Crown lengthening, in lieu of all other restorative treatment performed on the same tooth on the same day, is limited to one time per tooth per lifetime.
15. Relining or rebasing of complete or immediate dentures, as Dentally Necessary, within six months of installation of the replacement denture is limited to one. After the initial six months, relining and rebasing is limited to one per arch per year at the applicable dental copayment.
16. Pedodontic referral for children up to the sixth birthdate will be covered only after two attempts for treatment have been made by the Primary Dentist.
17. Specialty referral benefits are limited to necessary endodontic, periodontic and oral surgery procedures that cannot be rendered by the assigned Primary Dentist.
18. Consultation by a specialist for non-Covered Services is excluded.
19. Stayplates are only a benefit to replace extracted anterior teeth for adults.
20. Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other services (except x-rays) are rendered during the visit.

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EXCLUSION OF BENEFITS

Listed below are those services or expenses NOT covered under the plan that become the responsibility of the member at the Dentist's Usual and Customary fee.

1. Services to which you are entitled under any Workers' Compensation Law or Act or any other insurance plan, even if you did not claim those benefits.
2. Procedures that are: (a) not Dentally Necessary; or are (b) not customarily recognized throughout the dentist's field of specialty as essential for the treatment of the condition; (c) for services that are not prescribed by the attending Contracted Dentist.
3. Temporomandibular joint treatment (T.M.J.).
4. Elective or cosmetic dentistry, except as listed in the Benefit Schedule as a Covered Service and performed by a Contracted Dentist. Benefits for resin-based composite restorations on posterior teeth (behind the second bicuspid) will be based on the allowance for the corresponding amalgam restoration.
5. Oral surgery requiring the setting of fractures or dislocations. Orthognathic surgery or other oral surgical procedures solely for orthodontic purposes.
6. Loss or theft of full or partial dentures or other dental appliances.
7. Services including: (a) dispensing of drugs; (b) diagnostic photographs; (c) panoramic x-ray, except when used as part of a full mouth series in the Contracted Primary Dentist office only; (d) athletic mouthguards; (e) precision or semi-precision attachments; (f) denture duplication; (g) harmful habit appliances; (h) congenital or developmental malformations, including, but not limited to cleft palate, congenitally missing or supernumerary teeth; (i) a service not specifically listed as a covered benefit; (j) x-rays rendered at a specialist's office (except for authorized pedodontic referrals); (k) hospital charges of any kind.
8. Oral surgical procedures involving: (a) recontouring of hard and soft tissues; (b) sinus exploration; (c) oral antral fistulas; (d) removal of foreign bodies; (e) salivary glands and ducts; (f) the removal or treatment of cysts, tumors, or neoplasms.
9. Any procedure of implantation, reimplantation or related procedures.
10. Procedures that are considered Experimental or investigative or that are not widely accepted as proven and effective within the organized dental community.
11. General anesthesia, inhalation sedation, intravenous sedation, oral sedation drugs or intramuscular sedation.
12. Treatment or consultations rendered by a specialist if: (a) you are deemed unmanageable for treatment by the Primary Dentist, except for children up to the sixth birthdate; or (b) treatment cannot be rendered by the Primary Dentist due to your medical condition or physical limitations; or (c) a consultation is for non-Covered Services.
13. Dental expenses incurred under this dental plan that are in connection with any dental procedure started prior to your effective date under this Plan or after termination of your
14. Procedures relating to: (a) bite analysis; (b) the correction of abrasion, erosion, or attrition; (c) the change of contact or contour; (d) restorations for the purpose of splinting (except when necessary in conjunction with periodontal treatment); (e) grafting; (f) the treatment of non-pathologic conditions; and (g) overdentures and associated procedures.
15. Services that, in the opinion of the Plan, do not have a reasonable, favorable prognosis.
16. Disease contracted or injuries sustained as a result of a major disaster, war, declared or undeclared, epidemic conditions, or from exposure to nuclear energy, whether or not a result of war.
17. Further liability for additional treatment on a tooth when you and provider have elected a treatment plan that is disallowed by the Plan.
18. Crowns, inlays or onlays for teeth that can be satisfactorily restored by other means that meet professionally recognized standards.
19. All crowns and fixed or removable partial dentures for full mouth reconstruction, defined as treatment relating to: (a) the change of vertical dimension, or (b) the restoration of occlusion, or (c) extensive restorative treatment involving all remaining occluding teeth.
20. A Contracted Dentist may refuse treatment to any Member who continually fails to follow a prescribed course of treatment.

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Customer Service Phone Number 1-866-249-2382		Jade, Amber SNP CHF Core, Medicare DHMO Plans		EHB DHMO	
SPECIALTY REFFERAL:		DIRECT		PRE-AUTH	
Agreement ID:		SCFG00000285		SCFG00000284	
CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
CDT codes not listed are not a covered benefit / NTCV = Not Covered					
I. DIAGNOSTIC					
D0120	periodic oral evaluation – established patient	0		0	
D0140	limited oral evaluation – problem focused	0		0	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0		0	
D0150	comprehensive oral evaluation – new or established patient	0		0	
D0160	detailed and extensive oral evaluation – problem focused, by report	Not Covered		0	
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)	0		0	
D0171	re-evaluation – post-operative office visit	0		0	
D0180	comprehensive periodontal evaluation – new or established patient	0		0	
D0210	intraoral – complete series of radiographic images	0		0	
D0220	intraoral – periapical first radiographic image	0		0	
D0230	intraoral – periapical each additional radiographic image	0		0	
D0240	intraoral – occlusal radiographic image	0		0	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0		0	
D0251	extra-oral posterior dental radiographic image	0		0	
D0270	bitewing – single radiographic image	0		0	
D0272	bitewings – two radiographic images	0		0	
D0273	bitewings – three radiographic images	0		0	
D0274	bitewings – four radiographic images	0		0	
D0277	vertical bitewings – 7 to 8 radiographic images	0		0	
D0310	sialography	Not Covered		0	
D0320	temporomandibular joint arthrogram, including injection	Not Covered		0	
D0322	tomographic survey	Not Covered		0	
D0330	panoramic radiographic image	0		0	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	Not Covered		0	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0		0	
D0351	3D photographic image	0		0	
D0414	laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not Covered		0	
D0415	collection of microorganisms for culture and sensitivity	Not Covered		0	
D0425	caries susceptibility tests	Not Covered		0	
D0460	pulp vitality tests	0		0	
D0470	diagnostic casts	15		0	
D0472	accession of tissue, gross examination, preparation and transmission of written report	0		0	
D0473	accession of tissue, gross and microscopic examination, preparation and transmission of written report	0		0	
D0474	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	0		0	
D0502	other oral pathology procedures, by report	Not Covered		0	
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	0		0	
D0601	caries risk assessment and documentation, with a finding of low risk	Not Covered		0	

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CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D0602	caries risk assessment and documentation, with a finding of moderate risk	Not Covered		0	
D0603	caries risk assessment and documentation, with a finding of high risk	Not Covered		0	
D0999	encounter fee (only applicable to the EHB DHMO plan)	Not Applicable		0	2
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.					
II. PREVENTIVE					
D1110	prophylaxis – adult	0	3	0	
D1120	prophylaxis – child	0	3	0	
D1206	topical application of fluoride varnish	0		0	
D1208	topical application of fluoride – excluding varnish	Not Covered		0	
D1310	nutritional counseling for control of dental disease	0		0	
D1320	tobacco counseling for the control and prevention of oral disease	Not Covered		0	
D1330	oral hygiene instructions	0		0	
D1351	sealant – per tooth	12		0	5
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth	Not Covered		0	5
D1353	sealant repair – per tooth	12		0	
D1510	space maintainer – fixed, unilateral	55		0	115
D1516	space maintainer – fixed – bilateral, maxillary	55		0	115
D1517	space maintainer – fixed – bilateral, mandibular	55		0	115
D1520	space maintainer – removable – unilateral	55		0	115
D1526	space maintainer – removable – bilateral, maxillary	55		0	115
D1527	space maintainer – removable – bilateral, mandibular	55		0	115
D1550	re-cement or re-bond space maintainer	10		0	30
D1555	removal of fixed space maintainer	10		0	30
D1575	distal shoe space maintainer – fixed – unilateral	55		0	55
III. RESTORATIVE					
<ul style="list-style-type: none"> Dental copayments have an additional charge not to exceed the actual lab cost for precious and semi-precious metals for the Jade, Amber & Medicare DHMO plans. 					
¹ First Copayment applies to Product ID D0016391 & D0016392. The Second and Third Copayments reflect the copayment for primary versus permanent teeth for Product ID's D0011953, D0019968 & D0019969.					
D2140	amalgam – one surface, primary or permanent	0/10/18 ¹		25	50
D2150	amalgam – two surfaces, primary or permanent	0/12/20 ¹		30	55
D2160	amalgam – three surfaces, primary or permanent	0/16/22 ¹		40	65
D2161	amalgam – four or more surfaces, primary or permanent	27/24/27 ¹		45	70
D2330	resin-based composite – one surface, anterior	0/20 ¹	55	30	60
D2331	resin-based composite – two surfaces, anterior	0/24 ¹	60	45	65
D2332	resin-based composite – three surfaces, anterior	0/40 ¹	65	55	70
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)	0/50 ¹	70	60	75
D2390	resin-based composite crown, anterior	50	60	50	65
D2391	resin-based composite – one surface, posterior	80/45/80 ¹		30	65
D2392	resin-based composite – two surfaces, posterior	85/45/85 ¹		40	80
D2393	resin-based composite – three surfaces, posterior	90/55/90 ¹		50	90
D2394	resin-based composite – four or more surfaces, posterior	100/60/100 ¹		70	100

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		SPECIALTY REFFERAL: DIRECT		PRE-AUTH	
		Agreement ID: SCFG00000285		SCFG00000284	
CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D2510	inlay – metallic – one surface	225		235	260
D2520	inlay – metallic – two surfaces	225		245	270
D2530	inlay – metallic – three or more surfaces	225		260	285
D2610	inlay – porcelain/ceramic – one surface	Not Covered		275	300
D2620	inlay – porcelain/ceramic – two surfaces	Not Covered		285	310
D2630	inlay – porcelain/ceramic – three or more surfaces	Not Covered		300	325
D2650	inlay – resin-based composite – one surface	Not Covered		215	240
D2651	inlay – resin-based composite – two surfaces	Not Covered		235	260
D2652	inlay – resin-based composite – three or more surfaces	Not Covered		245	270
D2710	crown – resin-based composite (indirect)	Not Covered		140	175
D2712	crown – ¾ resin-based composite (indirect)	Not Covered		190	
D2721	crown – resin with predominantly base metal	Not Covered		300	430
D2740	crown – porcelain/ceramic	300	365	300	440
D2751	crown – porcelain fused to predominantly base metal	225	325	300	400
D2781	crown – ¾ cast predominantly base metal	225	325	300	400
D2783	crown – ¾ porcelain/ceramic	225	365	310	440
D2791	crown – full cast predominantly base metal	225	325	300	400
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	10		25	40
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	10		25	40
D2920	re-cement or re-bond crown	10		25	40
D2921	reattachment of tooth fragment, incisal edge or cusp	Not Covered		25	30
D2929	prefabricated porcelain/ceramic crown – primary tooth	Not Covered		95	
D2930	prefabricated stainless steel crown – primary tooth	25		65	105
D2931	prefabricated stainless steel crown – permanent tooth	35		75	120
D2932	prefabricated resin crown	Not Covered		75	120
D2933	prefabricated stainless steel crown with resin window	Not Covered		80	140
D2934	prefabricated esthetic coated stainless steel crown – primary tooth	Not Covered		115	135
D2940	protective restoration	0		25	30
D2941	interim therapeutic restoration – primary dentition	Not Covered		25	
D2949	restorative foundation for an indirect restoration	Not Covered		45	
D2950	core buildup, including any pins when required	30		20	85
D2951	pin retention – per tooth, in addition to restoration	15		25	
D2952	post and core in addition to crown, indirectly fabricated	75		100	130
D2953	each additional indirectly fabricated post – same tooth	40	50	30	70
D2954	prefabricated post and core in addition to crown	55		90	114
D2955	post removal	10		60	
D2957	each additional prefabricated post – same tooth	Not Covered		35	69
D2960	labial veneer (resin laminate) – chairside	Not Covered		270	
D2961	labial veneer (resin laminate) – laboratory	Not Covered		300	
D2971	additional procedures to construct new crown under existing partial denture framework	Not Covered		35	85

UHC will pay your office the difference between the Minimum Guarantee and the Member's Copayment.

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SPECIALTY REFFERAL:		DIRECT		PRE-AUTH	
Agreement ID:		SCFG00000285		SCFG00000284	
CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D2980	crown repair necessitated by restorative material failure	Not Covered		50	75
D2981	inlay repair necessitated by restorative material failure	Not Covered		70	75
D2982	onlay repair necessitated by restorative material failure	Not Covered		70	75
IV. ENDODONTICS					
D3110	pulp cap – direct (excluding final restoration)	5		20	
D3120	pulp cap – indirect (excluding final restoration)	5		25	
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	18		40	80
D3221	pulpal debridement, primary and permanent teeth	18	45	40	60
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	Not Covered		60	
D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	25	30	55	65
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	25	35	55	75
D3310	endodontic therapy, anterior tooth (excluding final restoration)	85	195	195	215
D3320	endodontic therapy, premolar tooth (excluding final restoration)	145	275	235	375
D3330	endodontic therapy, molar tooth (excluding final restoration)	225	365	300	450
D3331	treatment of root canal obstruction; non-surgical access	Not Covered		50	130
D3333	internal root repair of perforation defects	Not Covered		80	130
D3346	retreatment of previous root canal therapy – anterior	170		240	350
D3347	retreatment of previous root canal therapy – premolar	245		295	400
D3348	retreatment of previous root canal therapy – molar	275		365	440
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	65		85	130
D3352	apexification/recalcification – interim medication replacement	65		45	75
D3355	Pulpal regeneration - initial visit	Not Covered		110	130
D3356	Pulpal regeneration -interim medicament replacement	Not Covered		55	75
D3357	Pulpal regeneration - completion of treatment	Not Covered		175	205
D3410	apicoectomy – anterior	125		240	315
D3421	apicoectomy – premolar (first root)	150		250	345
D3425	apicoectomy – molar (first root)	160		275	375
D3426	apicoectomy (each additional root)	125		110	
D3427	periradicular surgery without apicoectomy	Not Covered		90	95
D3430	retrograde filling – per root	95		90	
D3910	surgical procedure for isolation of tooth with rubber dam	Not Covered		30	40
D3920	hemisection (including any root removal), not including root canal therapy	125		30	125
V. PERIODONTICS					
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	100		150	165
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	35	68	50	80
D4245	apically positioned flap	Not Covered		240	
D4249	clinical crown lengthening – hard tissue	160		165	175
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	350		265	415

UHC will pay your office the difference between the Minimum Guarantee and the Member's Copayment.

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SPECIALTY REFFERAL:		DIRECT		PRE-AUTH	
Agreement ID:		SCFG00000285		SCFG00000284	
CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	350		140	325
D4265	biologic materials to aid in soft and osseous tissue regeneration	Not Covered		80	
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	50	70	95	250
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	Not Covered		285	
D4341	periodontal scaling and root planing – four or more teeth per quadrant	40	50	55	70
D4342	periodontal scaling and root planing – one to three teeth per quadrant	40		30	40
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	35		30	70
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	40		40	70
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	60		10	35
D4910	periodontal maintenance	35		30	55
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	Not Covered		15	
VI. PROSTHODONTICS (REMOVABLE)					
¹ First Copayment applies to Product ID D0016391 & D0016392. The Second Copayment applies to Product ID's D0011953, D0019968 & D0019969.					
D5110	complete denture – maxillary	200	350	300	400
D5120	complete denture – mandibular	200	350	300	400
D5130	immediate denture – maxillary	0/200 ¹	335	300	350
D5140	immediate denture – mandibular	0/200 ¹	335	300	350
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	200	355	300	405
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	225	355	300	405
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	250	365	335	415
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	250	365	335	415
D5410	adjust complete denture – maxillary	15		20	30
D5411	adjust complete denture – mandibular	15		20	30
D5421	adjust partial denture – maxillary	15		20	30
D5422	adjust partial denture – mandibular	15		20	30
D5511	repair broken complete denture base, mandibular	15		20	30
D5512	repair broken complete denture base, maxillary	15		20	30
D5611	repair resin partial denture base, mandibular	15		20	60
D5612	repair resin partial denture base, maxillary	15		20	60
D5621	repair cast partial framework, mandibular	15		20	
D5622	repair cast partial framework, maxillary	15		20	
D5630	repair or replace broken clasp – per tooth	30	35	50	65
D5640	replace broken teeth – per tooth	35		35	53
D5650	add tooth to existing partial denture	35		35	60
D5660	add clasp to existing partial denture – per tooth	35		60	70
D5730	reline complete maxillary denture (chairside)	45		60	115
D5731	reline complete mandibular denture (chairside)	45		60	115
D5740	reline maxillary partial denture (chairside)	45		60	115
D5741	reline mandibular partial denture (chairside)	45		60	115

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CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D5750	reline complete maxillary denture (laboratory)	70		90	155
D5751	reline complete mandibular denture (laboratory)	70		90	155
D5760	reline maxillary partial denture (laboratory)	70		80	155
D5761	reline mandibular partial denture (laboratory)	70		80	155
D5820	interim partial denture (maxillary)	70		165	185
D5821	interim partial denture (mandibular)	70		165	185
D5850	tissue conditioning, maxillary	25		30	45
D5851	tissue conditioning, mandibular	25		30	45
D5862	precision attachment, by report	Not Covered		90	
D5865	overdenture - partial maxillary	Not Covered		300	415
D5866	overdenture - partial mandibular	Not Covered		300	415
D5867	replacement of replaceable part of semi-precision or precision attachment (male or female component)	Not Covered		300	
D5899	unspecified removable prosthodontic procedure, by report	Not Covered		350	
D5911	facial moulage (sectional)	Not Covered		285	
D5912	facial moulage (complete)	Not Covered		350	
D5913	nasal prosthesis	Not Covered		350	
D5914	auricular prosthesis	Not Covered		350	
D5915	orbital prosthesis	Not Covered		350	
D5916	ocular prosthesis	Not Covered		350	
D5919	facial prosthesis	Not Covered		350	
D5922	nasal septal prosthesis	Not Covered		350	
D5923	ocular prosthesis, interim	Not Covered		350	
D5924	cranial prosthesis	Not Covered		350	
D5925	facial augmentation implant prosthesis	Not Covered		200	
D5926	nasal prosthesis, replacement	Not Covered		200	
D5927	auricular prosthesis, replacement	Not Covered		200	
D5928	orbital prosthesis, replacement	Not Covered		200	
D5929	facial prosthesis, replacement	Not Covered		200	
D5931	obturator prosthesis, surgical	Not Covered		350	
D5932	obturator prosthesis, definitive	Not Covered		350	
D5933	obturator prosthesis, modification	Not Covered		150	
D5934	mandibular resection prosthesis with guide flange	Not Covered		350	
D5935	mandibular resection prosthesis without guide flange	Not Covered		350	
D5936	obturator prosthesis, interim	Not Covered		350	
D5937	trismus appliance (not for TMD treatment)	Not Covered		85	
D5951	feeding aid	Not Covered		135	
D5952	speech aid prosthesis, pediatric	Not Covered		350	
D5953	speech aid prosthesis, adult	Not Covered		350	
D5954	palatal augmentation prosthesis	Not Covered		135	
D5955	palatal lift prosthesis, definitive	Not Covered		350	

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Customer Service Phone Number 1-866-249-2382		Jade, Amber SNP CHF Core, Medicare DHMO Plans		EHB DHMO	
SPECIALTY REFFERAL:		DIRECT		PRE-AUTH	
Agreement ID:		SCFG00000285		SCFG00000284	
CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D5958	palatal lift prosthesis, interim	Not Covered		350	
D5959	palatal lift prosthesis, modification	Not Covered		145	
D5960	speech aid prosthesis, modification	Not Covered		145	
D5982	surgical stent	Not Covered		70	
D5983	radiation carrier	Not Covered		55	
D5984	radiation shield	Not Covered		85	
D5985	radiation cone locator	Not Covered		135	
D5986	fluoride gel carrier	Not Covered		35	
D5987	commissure splint	Not Covered		85	
D5988	surgical splint	Not Covered		95	
D5991	vesiculobullous disease medicament carrier	Not Covered		70	
VIII. IMPLANT SERVICES					
D6010	surgical placement of implant body: endosteal implant	Not Covered		350	1,035
D6011	second stage implant surgery	Not Covered		350	
D6013	surgical placement of a mini-implant	Not Covered		350	1,185
D6040	surgical placement: eosteal implant	Not Covered		350	1,185
D6050	surgical placement: transosteal implant	Not Covered		350	1,185
D6052	semi-precision attachment abutment	Not Covered		350	525
D6055	connecting bar – implant supported or abutment supported	Not Covered		350	390
D6056	prefabricated abutment – includes modification and placement	Not Covered		135	290
D6057	custom fabricated abutment – includes placement	Not Covered		180	395
D6058	abutment supported porcelain/ceramic crown	Not Covered		320	710
D6059	abutment supported porcelain fused to metal crown (high noble metal)	Not Covered		315	710
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	Not Covered		295	575
D6061	abutment supported porcelain fused to metal crown (noble metal)	Not Covered		300	635
D6062	abutment supported cast metal crown (high noble metal)	Not Covered		315	675
D6063	abutment supported cast metal crown (predominantly base metal)	Not Covered		300	595
D6064	abutment supported cast metal crown (noble metal)	Not Covered		315	620
D6065	implant supported porcelain/ceramic crown	Not Covered		340	740
D6066	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	Not Covered		335	720
D6067	implant supported metal crown (titanium, titanium alloy, high noble metal)	Not Covered		340	730
D6068	abutment supported retainer for porcelain/ceramic FPD	Not Covered		320	680
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	Not Covered		315	705
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	Not Covered		290	630
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	Not Covered		300	680
D6072	abutment supported retainer for cast metal FPD (high noble metal)	Not Covered		315	690
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	Not Covered		290	630
D6074	abutment supported retainer for cast metal FPD (noble metal)	Not Covered		320	670
D6075	implant supported retainer for ceramic FPD	Not Covered		335	740
D6076	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	Not Covered		330	705

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Agreement ID:		SCFG00000285		SCFG00000284	
CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D6077	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	Not Covered		350	665
D6080	implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	Not Covered		30	80
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	Not Covered		30	191
D6090	repair implant supported prosthesis, by report	Not Covered		65	130
D6091	replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	Not Covered		40	200
D6092	re-cement or re-bond implant/abutment supported crown	Not Covered		25	60
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	Not Covered		35	80
D6094	abutment supported crown (titanium)	Not Covered		295	560
D6095	repair implant abutment, by report	Not Covered		65	150
D6096	remove broken implant retaining screw	Not Covered		65	150
D6100	implant removal, by report	Not Covered		110	250
D6110	implant /abutment supported removable denture for edentulous arch – maxillary	Not Covered		350	925
D6111	implant /abutment supported removable denture for edentulous arch – mandibular	Not Covered		350	925
D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary	Not Covered		350	925
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular	Not Covered		350	925
D6114	implant /abutment supported fixed denture for edentulous arch – maxillary	Not Covered		350	925
D6115	implant /abutment supported fixed denture for edentulous arch – mandibular	Not Covered		350	925
D6116	implant /abutment supported fixed denture for partially edentulous arch – maxillary	Not Covered		350	925
D6117	implant /abutment supported fixed denture for partially edentulous arch – mandibular	Not Covered		350	925
D6118	implant/abutment supported interim fixed denture for edentulous arch - mandibular	Not Covered		350	925
D6119	implant/abutment supported interim fixed denture for edentulous arch - maxillary	Not Covered		350	925
D6190	radiographic/surgical implant index, by report	Not Covered		75	145
D6194	abutment supported retainer crown for FPD – (titanium)	Not Covered		265	575
VII. MAXILLOFACIAL PROSTHETICS					
• Dental copayments have an additional charge not to exceed the actual lab cost for precious and semi-precious metals for the Jade, Amber & Medicare DHMO plans.					
D6211	pontic – cast predominantly base metal	225		300	375
D6241	pontic – porcelain fused to predominantly base metal	225		300	375
D6245	pontic – porcelain/ceramic	225		300	415
D6251	pontic – resin with predominantly base metal	Not Covered		300	405
D6600	retainer inlay – porcelain/ceramic, two surfaces	Not Covered		285	310
D6601	retainer inlay – porcelain/ceramic, three or more surfaces	Not Covered		300	325
D6602	retainer inlay – cast high noble metal, two surfaces	Not Covered		245	270
D6603	retainer inlay – cast high noble metal, three or more surfaces	Not Covered		260	285
D6604	retainer inlay – cast predominantly base metal, two surfaces	Not Covered		235	260
D6605	retainer inlay – cast predominantly base metal, three or more surfaces	Not Covered		250	275
D6606	retainer inlay – cast noble metal, two surfaces	Not Covered		235	260
D6607	retainer inlay – cast noble metal, three or more surfaces	Not Covered		255	280
D6721	retainer crown – resin with predominantly base metal	Not Covered		300	405

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SPECIALTY REFFERAL:		DIRECT		PRE-AUTH	
Agreement ID:		SCFG00000285		SCFG00000284	
CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D6740	retainer crown – porcelain/ceramic	Not Covered		300	415
D6750	retainer crown – porcelain fused to high noble metal	225	365	300	415
D6751	retainer crown – porcelain fused to predominantly base metal	225	325	300	375
D6752	retainer crown – porcelain fused to noble metal	225	355	300	405
D6780	retainer crown – ¾ cast high noble metal	225	365	300	415
D6781	retainer crown – ¾ cast predominantly base metal	225	325	300	375
D6783	retainer crown – ¾ porcelain/ceramic	Not Covered		300	415
D6790	retainer crown – full cast high noble metal	225	365	300	415
D6791	retainer crown – full cast predominantly base metal	225	325	300	375
D6792	retainer crown – full cast noble metal	225	355	300	405
D6930	re-cement or re-bond fixed partial denture	0		40	53
D6940	stress breaker	Not Covered		120	130
D6980	fixed partial denture repair necessitated by restorative material failure	Not Covered		95	
X. ORAL AND MAXILLOFACIAL SURGERY					
¹ First Copayment applies to Product ID D0016391 & D0016392. The Second Copayment applies to Product ID's D0011953, D0019968 & D0019969.					
D7111	extraction, coronal remnants – primary tooth	15		40	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0/15 ¹		65	70
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	40		120	
D7220	removal of impacted tooth – soft tissue	60		95	
D7230	removal of impacted tooth – partially bony	80		145	
D7240	removal of impacted tooth – completely bony	125		160	165
D7241	removal of impacted tooth – completely bony, with unusual surgical complications	150		175	180
D7250	removal of residual tooth roots (cutting procedure)	0/50 ¹		80	175
D7260	oroantral fistula closure	Not Covered		280	
D7261	primary closure of a sinus perforation	Not Covered		285	
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	110		185	
D7280	exposure of an unerupted tooth	175		220	
D7282	mobilization of erupted or malpositioned tooth to aid eruption	Not Covered		135	145
D7283	placement of device to facilitate eruption of impacted tooth	Not Covered		85	
D7285	incisional biopsy of oral tissue – hard (bone, tooth)	60		180	
D7286	incisional biopsy of oral tissue – soft	60		110	
D7290	surgical repositioning of teeth	Not Covered		185	
D7291	transseptal fiberotomy/supra crestal fiberotomy, by report	Not Covered		80	
D7296	corticotomy - one to three teeth or tooth spaces, per quadrant	Not Covered		185	
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	Not Covered		185	
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	55		85	
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	18		50	
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	70		120	
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	23		65	70
D7340	vestibuloplasty – ridge extension (secondary epithelialization)	Not Covered		350	

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		Agreement ID: SCFG00000285		SCFG00000284	
CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D7350	vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Not Covered		350	
D7410	excision of benign lesion up to 1.25 cm	Not Covered		75	195
D7411	excision of benign lesion greater than 1.25 cm	Not Covered		115	400
D7412	excision of benign lesion, complicated	Not Covered		175	415
D7413	excision of malignant lesion up to 1.25 cm	Not Covered		95	195
D7414	excision of malignant lesion greater than 1.25 cm	Not Covered		120	400
D7415	excision of malignant lesion, complicated	Not Covered		255	415
D7440	excision of malignant tumor – lesion diameter up to 1.25 cm	Not Covered		105	195
D7441	excision of malignant tumor – lesion diameter greater than 1.25 cm	Not Covered		185	400
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	Not Covered		180	230
D7451	removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	Not Covered		330	335
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	Not Covered		155	230
D7461	removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	Not Covered		250	335
D7465	destruction of lesion(s) by physical or chemical method, by report	Not Covered		40	
D7471	removal of lateral exostosis (maxilla or mandible)	Not Covered		140	195
D7472	removal of torus palatinus	Not Covered		145	350
D7473	removal of torus mandibularis	Not Covered		140	315
D7485	reduction of osseous tuberosity	Not Covered		105	
D7490	radical resection of maxilla or mandible	Not Covered		350	
D7510	incision and drainage of abscess – intraoral soft tissue	0	30	70	
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	0	30	70	
D7520	incision and drainage of abscess – extraoral soft tissue	Not Covered		70	325
D7521	incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	Not Covered		80	400
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Not Covered		45	
D7540	removal of reaction producing foreign bodies, musculoskeletal system	Not Covered		75	
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	Not Covered		125	
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	Not Covered		235	
D7610	maxilla – open reduction (teeth immobilized, if present)	Not Covered		140	
D7620	maxilla – closed reduction (teeth immobilized, if present)	Not Covered		250	
D7630	mandible – open reduction (teeth immobilized, if present)	Not Covered		350	
D7640	mandible – closed reduction (teeth immobilized, if present)	Not Covered		350	
D7650	malar and/or zygomatic arch - open reduction	Not Covered		350	
D7660	malar and/or zygomatic arch – closed reduction	Not Covered		350	
D7670	alveolus – closed reduction, may include stabilization of teeth	Not Covered		170	
D7671	alveolus – open reduction, may include stabilization of teeth	Not Covered		230	
D7680	facial bones – complicated reduction with fixation and multiple surgical approaches	Not Covered		350	
D7710	maxilla – open reduction	Not Covered		110	
D7720	maxilla – closed reduction	Not Covered		180	
D7730	mandible – open reduction	Not Covered		350	

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Agreement ID:		SCFG00000285		SCFG00000284	
CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D7740	mandible – closed reduction	Not Covered		290	
D7750	malar and/or zygomatic arch – open reduction	Not Covered		220	
D7760	malar and/or zygomatic arch – closed reduction	Not Covered		350	
D7770	alveolus – open reduction stabilization of teeth	Not Covered		135	
D7771	alveolus, closed reduction stabilization of teeth	Not Covered		160	
D7780	facial bones – complicated reduction with fixation and multiple surgical approaches	Not Covered		350	
D7810	open reduction of dislocation	Not Covered		350	
D7820	closed reduction of dislocation	Not Covered		80	
D7830	manipulation under anesthesia	Not Covered		85	
D7840	condylectomy	Not Covered		350	
D7850	surgical discectomy, with/without implant	Not Covered		350	
D7852	disc repair	Not Covered		350	
D7854	synovectomy	Not Covered		350	
D7856	myotomy	Not Covered		350	
D7858	joint reconstruction	Not Covered		350	
D7860	arthrotomy	Not Covered		350	
D7865	arthroplasty	Not Covered		350	
D7870	arthrocentesis	Not Covered		90	
D7871	non-arthroscopic lysis and lavage	Not Covered		150	
D7872	arthroscopy – diagnosis, with or without biopsy	Not Covered		350	
D7873	arthroscopy – surgical: lavage and lysis of adhesions	Not Covered		350	
D7874	arthroscopy – surgical: disc repositioning and stabilization	Not Covered		350	
D7875	arthroscopy – surgical: synovectomy	Not Covered		350	
D7876	arthroscopy – surgical: discectomy	Not Covered		350	
D7877	arthroscopy – surgical: debridement	Not Covered		350	
D7880	occlusal orthotic device, by report	Not Covered		120	
D7910	suture of recent small wounds up to 5 cm	Not Covered		35	40
D7911	complicated suture – up to 5 cm	Not Covered		55	
D7912	complicated suture – greater than 5 cm	Not Covered		130	
D7920	skin graft (identify defect covered, location and type of graft)	Not Covered		120	
D7940	osteoplasty – for orthognathic deformities	Not Covered		160	
D7944	osteotomy – segmented or subapical	Not Covered		275	
D7946	LeFort I (maxilla – total)	Not Covered		350	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	Not Covered		350	
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	Not Covered		190	
D7952	Sinus augmentation via a vertical approach	Not Covered		175	
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	45		120	
D7963	frenuloplasty	45		120	
D7970	excision of hyperplastic tissue – per arch	Not Covered		175	
D7971	excision of pericoronal gingiva	60		80	

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CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D7972	surgical reduction of fibrous tuberosity	Not Covered		100	150
D7981	excision of salivary gland, by report	Not Covered		120	
D7982	sialodochoplasty	Not Covered		215	
D7983	closure of salivary fistula	Not Covered		140	
D7990	emergency tracheotomy	Not Covered		350	
D7991	coronoidectomy	Not Covered		345	
D7995	synthetic graft – mandible or facial bones, by report	Not Covered		150	
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	Not Covered		60	
XII. ADJUNCTIVE GENERAL SERVICES					
D9110	palliative (emergency) treatment of dental pain – minor procedure	0		30	
D9120	fixed partial denture sectioning	0		95	
D9210	local anesthesia not in conjunction with operative or surgical procedures	0		10	
D9211	regional block anesthesia	0		20	
D9212	trigeminal division block anesthesia	Not Covered		60	
D9215	local anesthesia in conjunction with operative or surgical procedures	0		15	
D9222	deep sedation/general anesthesia – first 15 minutes	60		45	60
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment	60		45	60
D9230	inhalation of nitrous oxide/anxiolysis, analgesia	Not Covered		15	20
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	60		60	
D9243	intravenous moderate (conscious) sedation/anesthesia – each subsequent 15 minute increment	60		60	
D9248	non-intravenous conscious sedation	Not Covered		65	
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	0	20	50	
D9311	consultation with a medical health care professional	0		20	100
D9410	house/extended care facility call	Not Covered		50	
D9420	hospital or ambulatory surgical center call	Not Covered		135	
D9430	office visit for observation (during regularly scheduled hours) – no other services performed	0		20	25
D9440	office visit – after regularly scheduled hours	20	30	45	
D9610	therapeutic parenteral drug, single administration	Not Covered		30	
D9612	therapeutic parenteral drugs, two or more administrations, different medications	Not Covered		40	
D9910	application of desensitizing medicament	15		20	
D9920	behavior management, by report	Not Covered		35	
D9930	treatment of complications (post-surgical) – unusual circumstances, by report	Not Covered		35	
D9950	occlusion analysis – mounted case	Not Covered		120	
D9951	occlusal adjustment – limited	0	15	45	60
D9952	occlusal adjustment – complete	75		210	
D9972	external bleaching – per arch – performed in office	125		125	
D9991	dental case management - addressing appointment compliance barriers	Not Covered		35	
D9992	dental case management - care coordination	Not Covered		35	
D9993	dental case management - motivational interviewing	Not Covered		35	
D9994	dental case management - patient education to improve oral health literacy	Not Covered		35	

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CDT Code	CDT Description	Member Copayment	Minimum Guarantee	Member Copayment	Minimum Guarantee
D9995	teledentistry – synchronous; real-time encounter	0		0	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0		0	
XI. ORTHODONTICS					
• Orthodontia is only covered for medically necessary banded cases on the EHB DHMO plan.					
D8050	interceptive orthodontic treatment of the primary dentition	725		Not Covered	
D8060	interceptive orthodontic treatment of the transitional dentition	725		Not Covered	
D8070	comprehensive orthodontic treatment of the transitional dentition	1,950		1,000	
D8080	comprehensive orthodontic treatment of the adolescent dentition	1,950		1,000	
D8090	comprehensive orthodontic treatment of the adult dentition	2,250		1,000	
D8210	removable appliance therapy	Not Covered		0	
D8220	fixed appliance therapy	Not Covered		0	
D8660	pre-orthodontic treatment examination to monitor growth and development	0		0	
D8670	periodic orthodontic treatment visit	0		0	
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))	250		0	
D8691	repair of orthodontic appliance	Not Covered		0	
D8692	replacement of lost or broken retainer	Not Covered		0	
D8693	re-cement or re-bond fixed retainer	0		0	
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	250		0	
D8999	Start Up fee (including exam, beginning records, x-ray, tracings, photos and models) construction replacement of retainers	250		0	
D8999	Post treatment records	150		0	
D8999	Monthly orthodontic fee (for comprehensive treatment beyond 24 months)	35		0	

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.

**HEALTH NET OF CALIFORNIA / CENTENE
JADE, AMBER SNP CHF CORE & MEDICARE DHMO PLANS**

Customer Service Phone Number 1-866-249-2382		Jade, Amber SNP CHF Core & Medicare Plans
MATERIAL UPGRADES FOR NON-ELECTIVE DENTAL SERVICES (COSTS REFLECTED BELOW ARE IN ADDITION TO COPAYMENT FOR SERVICES)		
CDT Code	Description	Member Copayment
D2750	Porcelain on molars ²	75
D2999	Noble or high noble metal for crowns – lab cost ²	Lab cost
D2740	Lucite-reinforced pressed crown/Empress ²	300 + Copayment
D2750	Gold composite reinforced crown/Captek ²	300 + Copayment
D5110	Comfort Flex (complete upper denture) acetyl resin homopolymer ²	400 + Copayment
D5120	Comfort Flex (complete lower denture) acetyl resin homopolymer ²	400 + Copayment
D5211	Comfort Flex (upper partial denture) acetyl resin homopolymer ²	425 + Copayment
D5212	Comfort Flex (lower partial denture) acetyl resin homopolymer ²	425 + Copayment
² In addition to copayment for services.		
COSMETIC DENTAL SERVICES (ELECTIVE SERVICES)		
CDT Code	Description	Member Copayment
D2330	Resin based-composite, one surface anterior	80
D2331	Resin based-composite, two surfaces anterior	95
D2332	Resin based-composite, three surfaces anterior	105
D2335	Resin based-composite, four or more surfaces or involving incisal angle (anterior)	125
D2391	Resin based-composite, one surface posterior	85
D2392	Resin based-composite, two surfaces posterior	100
D2393	Resin based-composite, three surfaces posterior	110
D2394	Resin based-composite, four or more surfaces posterior	130
D2740	Lucite-reinforced pressed crown/Empress	700
D2962	Labial veneer/porcelain laminate	450
D5110	Comfort Flex (complete upper denture) acetyl resin homopolymer	650
D5120	Comfort Flex (complete lower denture) acetyl resin homopolymer	650
D5211	Comfort Flex (upper partial denture) acetyl resin homopolymer	725
D5212	Comfort Flex (lower partial denture) acetyl resin homopolymer	725
D9972	External bleaching – per arch	125
EMERGENCY DENTAL CARE (NON ROUTINE, NON MEDICARE-COVERED)		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	No Charge

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.

LIMITATION OF BENEFITS

Please refer to the Dental Covered Services Schedule to determine your copayment responsibility. Multi-year benefits may not be available in subsequent years.

1. Prophylaxis (cleaning) is limited to two per calendar year at no charge. Additional prophylaxis services will be at a copayment of \$40 for adults (age 18 and older) and \$25 for children (age 17 and under).
2. Fluoride treatment is limited to once every calendar year for adults (age 18 and older) and children (age 17 and under).
3. Bitewing x-rays are limited to one series of four films in any calendar year.
4. Full mouth x-rays are limited to once every twenty-four consecutive months.
5. Sealants are covered up to the fourteenth birth date and are limited to permanent first and second molars only.
6. Periodontal treatments (gingival curettage and root planing) are limited to four separate quadrants in any twelve consecutive months and no more than two quadrants per date of service.
7. Periodontal maintenance procedure/ periodontal prophylaxis (including minor scaling) is limited to two per calendar year following scaling and root planing (active therapy).
8. Periodontal surgery (gingivectomy or osseous mucogingival) is limited to once per quadrant in any thirty-six consecutive months.
9. A full or removable partial, upper/lower denture is not to exceed one each in any five year period, and only if it is unsatisfactory and cannot be made satisfactory by either reline or repair.
10. Replacement of a restoration is covered only when it is Dentally Necessary.
11. Fixed partial dentures will be covered only when a removable partial denture cannot satisfactorily restore the case. If fixed partial dentures are used when a removable partial denture could satisfactorily restore the case, then the fixed partial denture is considered to be Optional Treatment.
12. Full cast crowns, porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. The Plan covers an acrylic or stainless steel crown.
13. A crown placed on a specific tooth is covered only once in any five-year period and only if it cannot be repaired and restored to natural function. A maximum of five units of crown and removable partial dentures will be covered in any one arch, in accordance with the Plan's policies and procedures.
14. Crown lengthening, in lieu of all other restorative treatment performed on the same tooth on the same day, is limited to one time per tooth per lifetime.
15. Relining or rebasing of complete or immediate dentures, as Dentally Necessary, within six months of installation of the replacement denture is limited to one. After the initial six months, relining and rebasing is limited to one per arch per year at the applicable dental copayment.
16. Pedodontic referral for children up to the sixth birth date will be covered only after two attempts for treatment have been made by the Primary Dentist.
17. Specialty referral benefits are limited to necessary endodontic, periodontic and oral surgery procedures that cannot be rendered by the assigned Primary Dentist.
18. Consultation by a specialist for non-Covered Services is excluded.
19. Stayplates are only a benefit to replace extracted anterior teeth for adults.
20. Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other services (except x-rays) are rendered during the visit.

OPTIONAL TREATMENT PROVISIONS

If (1) a less expensive alternative procedure, service or course of treatment can be performed in place of the proposed treatment to correct a dental condition, as determined by the Plan; and (2) the alternate treatment will produce a professionally satisfactory result; then the maximum eligible dental expense to be considered for payment will be the less expensive treatment.

EXCLUSION OF BENEFITS

Payment will not be made for:

1. Services to which you are entitled under any Workers' Compensation Law or Act or any other insurance plan, even if you did not claim those benefits.
2. Procedures that are: (a) not Dentally Necessary; or are (b) not customarily recognized throughout the dentist's field of specialty as essential for the treatment of the condition; (c) for services that are not prescribed by the attending Contracted Dentist.
3. Temporomandibular joint treatment (T.M.J.).
4. Elective or cosmetic dentistry, except as listed in the Benefit Schedule as a Covered Service and performed by a Contracted Dentist. Benefits for resin-based composite restorations on posterior teeth (behind the second bicuspid) will be based on the allowance for the corresponding amalgam restoration.
5. Oral surgery requiring the setting of fractures or dislocations. Orthognathic surgery or other oral surgical procedures solely for orthodontic purposes.
6. Loss or theft of full or partial dentures or other dental appliances.

HEALTH NET OF CA AND CENTENE (JADE, AMBER CORE AND MEDICARE) DHMO PLANS LIMITATIONS AND EXCLUSIONS OF BENEFITS



EXHIBIT 2

7. Services including:
 - a. dispensing of drugs;
 - b. diagnostic photographs;
 - c. panoramic x-ray, except when used as part of a full mouth series in the Contracted Primary Dentist office only;
 - d. athletic mouthguards;
 - e. precision or semi-precision attachments;
 - f. denture duplication;
 - g. harmful habit appliances;
 - h. congenital or developmental malformations, including, but not limited to cleft palate, congenitally missing or supernumerary teeth;
 - i. a service not specifically listed as a covered benefit;
 - j. x-rays rendered at a specialist's office (except for authorized pedodontic referrals);
 - k. hospital charges of any kind.
8. Oral surgical procedures involving:
 - a. recontouring of hard and soft tissues;
 - b. sinus exploration;
 - c. oral antral fistulas;
 - d. removal of foreign bodies;
 - e. salivary glands and ducts;
 - f. the removal or treatment of cysts, tumors, or neoplasms.
9. Any procedure of implantation, reimplantation or related procedures.
10. Procedures that are considered Experimental or investigative or that are not widely accepted as proven and effective within the organized dental community.
11. Inhalation sedation, oral sedation drugs or intramuscular sedation.
12. Treatment or consultations rendered by a specialist if:
 - a. you are deemed unmanageable for treatment by the Primary Dentist, except for children up to the sixth birth date; or
 - b. treatment cannot be rendered by the Primary Dentist due to your medical condition or physical limitations; or
 - c. a consultation is for non-Covered Services.
13. Dental expenses incurred under this dental plan that are in connection with any dental procedure started prior to your effective date under this Plan or after termination of your coverage.
14. Procedures relating to:
 - a. bite analysis;
 - b. the correction of abrasion, erosion, or attrition;
 - c. the change of contact or contour;
 - d. restorations for the purpose of splinting (except when necessary in conjunction with periodontal treatment);
 - e. grafting;
 - f. the treatment of non-pathologic conditions; and
 - g. overdentures and associated procedures.
15. Services that, in the opinion of the Plan, do not have a reasonable, favorable prognosis.
16. Disease contracted or injuries sustained as a result of a major disaster, war, declared or undeclared, epidemic conditions, or from exposure to nuclear energy, whether or not a result of war.
17. Further liability for additional treatment on a tooth when you and provider have elected a treatment plan that is disallowed by the Plan. (You may appeal denial.)
18. Crowns, inlays or onlays for teeth that can be satisfactorily restored by other means that meet professionally recognized standards.
19. All crowns and fixed or removable partial dentures for full mouth reconstruction, defined as treatment relating to:
 - a. the change of vertical dimension, or

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LIMITATIONS AND EXCLUSIONS OF BENEFITS**



EXHIBIT 2

- b. the restoration of occlusion, or
 - c. extensive restorative treatment involving all remaining occluding teeth.
20. A Contracted Dentist may refuse treatment to any Member who continually fails to follow a prescribed course of treatment.

ORTHODONTIC LIMITATION & EXCLUSIONS

1. Orthodontic benefits are available only at Contracted Orthodontic offices.
2. If you relocate to an area and are unable to receive treatment with the original Contracted Orthodontist, coverage under this program ceases and it becomes your obligation to pay the Usual and Customary Reasonable Fee (UCR) of the orthodontist where the treatment is completed.
3. Covered treatment cannot be transferred by you from one Contracted Orthodontist to another Contracted Orthodontist.
4. No benefit will be paid for an orthodontic treatment program that began before you enrolled in the Orthodontic Plan.
5. Plan benefits are limited to 24 months of usual and customary orthodontic treatment (Phase 2 treatment banding).
6. If you become ineligible during the course of treatment, coverage under this program ceases and it becomes your obligation to pay the Usual and Customary Reasonable Fee (UCR) incurred for the entire remaining balance of treatment.
7. Orthognathic surgery cases and cases involving cleft palate, micrognathia, macroglossia, hormonal imbalances, temporomandibular joint disorders (T.M.J.), or myofunctional therapy.
8. Re-treatment of orthodontic cases, changes in treatment necessitated by an accident of any kind, and treatment due to neglect or non-cooperation are excluded.
9. The following are not included in the orthodontic benefits and the orthodontist's usual and customary charges apply:
 - a. initial diagnostic work-up and x-rays;
 - b. tracings;
 - c. Phase 1 orthodontic treatment (prior to full mouth banding)
 - d. records; functional appliances; headgear; pre-banding devices, appliances or therapy; biteplanes; palatal expansion appliances; thumb or tongue appliances; positioners; active vertical correctors; or tooth guidance appliances.
 - e. lingual or clear brackets;
 - f. extractions or other oral surgical procedures for orthodontic purposes;
 - g. study models;
 - h. replacement of lost or broken appliances, bands, brackets or orthodontic retainers.

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		SPECIALTY REFERRAL:	PRE-AUTH	
		Agreement ID:	SCFG00000286	
CDT Code	Description		Copayment	Minimum Guarantee
CDT codes not listed are not a covered benefit				
I. DIAGNOSTIC				
D0120	periodic oral evaluation – established patient		0	0
D0140	limited oral evaluation – problem focused		0	0
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver		0	0
D0150	comprehensive oral evaluation – new or established patient		0	0
D0160	detailed and extensive oral evaluation – problem focused, by report		0	0
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)		0	0
D0180	comprehensive periodontal evaluation – new or established patient		0	0
D0210	intraoral – complete series of radiographic images		0	0
D0220	intraoral – periapical first radiographic image		0	0
D0230	intraoral – periapical each additional radiographic image		0	0
D0240	intraoral – occlusal radiographic image		0	0
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector		0	0
D0251	extra-oral posterior dental radiographic image		0	0
D0270	bitewing – single radiographic image		0	0
D0272	bitewings – two radiographic images		0	0
D0273	bitewings – three radiographic images		0	0
D0274	bitewings – four radiographic images		0	0
D0277	vertical bitewings – 7 to 8 radiographic images		0	0
D0330	panoramic radiographic image		0	0
D0414	laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report		0	0
D0415	collection of microorganisms for culture and sensitivity		0	0
D0422	collection and preparation of genetic sample material for laboratory analysis and report		0	0
D0423	genetic test for susceptibility to diseases – specimen analysis		0	0
D0425	caries susceptibility tests		0	0
D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures		0	45
D0460	pulp vitality tests		0	0
D0470	diagnostic casts		0	0
D0472	accession of tissue, gross examination, preparation and transmission of written report		0	0
D0473	accession of tissue, gross and microscopic examination, preparation and transmission of written report		0	0
D0474	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report		0	0
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum		0	0
D0601	caries risk assessment and documentation, with a finding of low risk		0	0

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CDT Code	Description		Copayment	Minimum Guarantee
D0602	caries risk assessment and documentation, with a finding of moderate risk		0	0
D0603	caries risk assessment and documentation, with a finding of high risk		0	0
D0999	encounter fee		0	2
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.				
II. PREVENTIVE				
D1110	prophylaxis – adult		0	0
D1110	additional prophylaxis – adult (3rd within a Year)		0	0
D1120	prophylaxis – child		0	0
D1120	additional prophylaxis – child (3rd within a Year)		0	0
D1206	topical application of fluoride varnish		0	0
D1208	topical application of fluoride – excluding varnish		0	0
D1310	nutritional counseling for control of dental disease		0	0
D1320	tobacco counseling for the control and prevention of oral disease		0	0
D1330	oral hygiene instructions		0	0
D1351	sealant – per tooth		0	5
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth		0	5
D1353	sealant repair – per tooth		0	0
D1510	space maintainer – fixed, unilateral		0	115
D1516	space maintainer – fixed – bilateral, maxillary		0	115
D1517	space maintainer – fixed – bilateral, mandibular		0	115
D1520	space maintainer – removable – unilateral		0	115
D1526	space maintainer – removable – bilateral, maxillary		0	115
D1527	space maintainer – removable – bilateral, mandibular		0	115
D1550	re-cement or re-bond space maintainer		0	30
D1555	removal of fixed space maintainer		0	30
D1575	distal shoe space maintainer – fixed – unilateral		0	0
III. RESTORATIVE				
D2140	amalgam – one surface, primary or permanent		0	50
D2150	amalgam – two surfaces, primary or permanent		0	55
D2160	amalgam – three surfaces, primary or permanent		0	65
D2161	amalgam – four or more surfaces, primary or permanent		0	70
D2330	resin-based composite – one surface, anterior		0	60
D2331	resin-based composite – two surfaces, anterior		0	65
D2332	resin-based composite – three surfaces, anterior		0	70
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		0	75

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CDT Code	Description		Copayment	Minimum Guarantee
D2390	resin-based composite crown, anterior		0	65
D2391	resin-based composite – one surface, posterior		0	65
D2392	resin-based composite – two surfaces, posterior		0	80
D2393	resin-based composite – three surfaces, posterior		0	90
D2394	resin-based composite – four or more surfaces, posterior		0	100
D2510	inlay – metallic – one surface		0	260
D2520	inlay – metallic – two surfaces		0	270
D2530	inlay – metallic – three or more surfaces		0	285
D2542	onlay – metallic – two surfaces		0	300
D2543	onlay – metallic – three surfaces		0	310
D2544	onlay – metallic – four or more surfaces		0	325
D2610	inlay – porcelain/ceramic – one surface		0	300
D2620	inlay – porcelain/ceramic – two surfaces		0	310
D2630	inlay – porcelain/ceramic – three or more surfaces		0	325
D2642	onlay – porcelain/ceramic – two surfaces		0	310
D2643	onlay – porcelain/ceramic – three surfaces		0	325
D2644	onlay – porcelain/ceramic – four or more surfaces		0	325
D2650	inlay – resin-based composite – one surface		0	240
D2651	inlay – resin-based composite – two surfaces		0	260
D2652	inlay – resin-based composite – three or more surfaces		0	270
D2662	onlay – resin-based composite – two surfaces		0	250
D2663	onlay – resin-based composite – three surfaces		0	280
D2664	onlay – resin-based composite – four or more surfaces		0	300
D2710	crown – resin-based composite (indirect)		0	175
D2712	crown – ¾ resin-based composite (indirect)		0	175
D2720	crown – resin with high noble metal		0	440
D2721	crown – resin with predominantly base metal		0	430
D2722	crown – resin with noble metal		0	430
D2740	crown – porcelain/ceramic		0	440
D2750	crown – porcelain fused to high noble metal		0	440
D2751	crown – porcelain fused to predominantly base metal		0	400
D2752	crown – porcelain fused to noble metal		0	430
D2780	crown – ¾ cast high noble metal		0	440
D2781	crown – ¾ cast predominantly base metal		0	400
D2782	crown – ¾ cast noble metal		0	430
D2783	crown – ¾ porcelain/ceramic		0	440

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CDT Code	Description		Copayment	Minimum Guarantee
D2790	crown – full cast high noble metal		0	440
D2791	crown – full cast predominantly base metal		0	400
D2792	crown – full cast noble metal		0	430
D2794	crown – titanium		0	440
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		0	40
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		0	40
D2920	re-cement or re-bond crown		0	40
D2921	reattachment of tooth fragment, incisal edge or cusp		0	30
D2930	prefabricated stainless steel crown – primary tooth		0	105
D2931	prefabricated stainless steel crown – permanent tooth		0	120
D2932	prefabricated resin crown		0	120
D2933	prefabricated stainless steel crown with resin window		0	140
D2934	prefabricated esthetic coated stainless steel crown – primary tooth		0	135
D2940	protective restoration		0	30
D2941	interim therapeutic restoration – primary dentition		0	25
D2950	core buildup, including any pins when required		0	85
D2951	pin retention – per tooth, in addition to restoration		0	20
D2952	post and core in addition to crown, indirectly fabricated		0	130
D2953	each additional indirectly fabricated post – same tooth		0	70
D2954	prefabricated post and core in addition to crown		0	114
D2955	post removal		0	40
D2957	each additional prefabricated post – same tooth		0	69
D2960	labial veneer (resin laminate) – chairside		0	270
D2962	labial veneer (porcelain laminate) – laboratory		0	375
D2971	additional procedures to construct new crown under existing partial denture framework		0	85
D2980	crown repair necessitated by restorative material failure		0	75
D2981	inlay repair necessitated by restorative material failure		0	75
D2982	onlay repair necessitated by restorative material failure		0	75
IV. ENDODONTICS				
D3110	pulp cap – direct (excluding final restoration)		0	20
D3120	pulp cap – indirect (excluding final restoration)		0	20
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament		0	80
D3221	pulpal debridement, primary and permanent teeth		0	60
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development		0	60
D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		0	65
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)		0	75

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CDT Code	Description		Copayment	Minimum Guarantee
D3310	endodontic therapy, anterior tooth (excluding final restoration)		0	215
D3320	endodontic therapy, premolar tooth (excluding final restoration)		0	375
D3330	endodontic therapy, molar tooth (excluding final restoration)		0	450
D3331	treatment of root canal obstruction; non-surgical access		0	130
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		0	130
D3333	internal root repair of perforation defects		0	130
D3346	retreatment of previous root canal therapy – anterior		0	350
D3347	retreatment of previous root canal therapy – premolar		0	400
D3348	retreatment of previous root canal therapy – molar		0	440
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)		0	130
D3352	apexification/recalcification – interim medication replacement		0	75
D3353	apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)		0	205
D3355	Pulpal regeneration - initial visit		0	130
D3356	Pulpal regeneration -interim medicament replacement		0	75
D3357	Pulpal regeneration - completion of treatment		0	205
D3410	apicoectomy – anterior		0	315
D3421	apicoectomy – premolar (first root)		0	345
D3425	apicoectomy – molar (first root)		0	375
D3426	apicoectomy (each additional root)		0	95
D3427	periradicular surgery without apicoectomy		0	95
D3430	retrograde filling – per root		0	70
D3450	root amputation – per root		0	155
D3910	surgical procedure for isolation of tooth with rubber dam		0	40
D3920	hemisection (including any root removal), not including root canal therapy		0	125
D3950	canal preparation and fitting of preformed dowel or post		0	40
V. PERIODONTICS				
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant		0	165
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant		0	80
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant		0	225
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant		0	155
D4245	apically positioned flap		0	240
D4249	clinical crown lengthening – hard tissue		0	175
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant		0	415
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant		0	325

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CDT Code	Description		Copayment	Minimum Guarantee
D4263	bone replacement graft – retained natural tooth – first site in quadrant		0	225
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant		0	135
D4270	pedicle soft tissue graft procedure		0	285
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)		0	95
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft		0	285
D4341	periodontal scaling and root planing – four or more teeth per quadrant		0	70
D4342	periodontal scaling and root planing – one to three teeth per quadrant		0	40
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		0	45
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit		0	70
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth		0	35
D4910	periodontal maintenance		0	55
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)		0	0
VI. PROSTHODONTICS (REMOVABLE)				
D5110	complete denture – maxillary		0	400
D5120	complete denture – mandibular		0	400
D5130	immediate denture – maxillary		0	350
D5140	immediate denture – mandibular		0	350
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		0	405
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		0	405
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		0	415
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		0	415
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		0	185
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		0	185
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		0	230
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		0	230
D5225	maxillary partial denture – flexible base (including any clasps, rests and teeth)		0	425
D5226	mandibular partial denture – flexible base (including any clasps, rests and teeth)		0	425
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary		0	340
D5283	removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular		0	340
D5410	adjust complete denture – maxillary		0	30
D5411	adjust complete denture – mandibular		0	30
D5421	adjust partial denture – maxillary		0	30
D5422	adjust partial denture – mandibular		0	30
D5511	repair broken complete denture base, mandibular		0	60
D5512	repair broken complete denture base, maxillary		0	60
D5520	replace missing or broken teeth – complete denture (each tooth)		0	50

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		SPECIALTY REFERRAL:	PRE-AUTH	
		Agreement ID:	SCFG00000286	
CDT Code	Description		Copayment	Minimum Guarantee
D5611	repair resin partial denture base, mandibular		0	60
D5612	repair resin partial denture base, maxillary		0	60
D5621	repair cast partial framework, mandibular		0	60
D5622	repair cast partial framework, maxillary		0	60
D5630	repair or replace broken clasp – per tooth		0	65
D5640	replace broken teeth – per tooth		0	53
D5650	add tooth to existing partial denture		0	60
D5660	add clasp to existing partial denture – per tooth		0	70
D5670	replace all teeth and acrylic on cast metal framework (maxillary)		0	195
D5671	replace all teeth and acrylic on cast metal framework (mandibular)		0	195
D5710	rebase complete maxillary denture		0	200
D5711	rebase complete mandibular denture		0	200
D5720	rebase maxillary partial denture		0	190
D5721	rebase mandibular partial denture		0	190
D5730	reline complete maxillary denture (chairside)		0	115
D5731	reline complete mandibular denture (chairside)		0	115
D5740	reline maxillary partial denture (chairside)		0	115
D5741	reline mandibular partial denture (chairside)		0	115
D5750	reline complete maxillary denture (laboratory)		0	155
D5751	reline complete mandibular denture (laboratory)		0	155
D5760	reline maxillary partial denture (laboratory)		0	155
D5761	reline mandibular partial denture (laboratory)		0	155
D5820	interim partial denture (maxillary)		0	185
D5821	interim partial denture (mandibular)		0	185
D5850	tissue conditioning, maxillary		0	45
D5851	tissue conditioning, mandibular		0	45
D5863	overdenture - complete maxillary		0	400
D5864	overdenture - complete mandibular		0	400
D5865	overdenture - partial maxillary		0	415
D5866	overdenture - partial mandibular		0	415
D5876	add metal substructure to acrylic full denture (per arch)		0	200
D5999	unspecified maxillofacial prosthesis, by report		0	245
IX. PROSTHODONTICS, FIXED				
D6205	pontic – indirect resin based composite		0	195
D6210	pontic – cast high noble metal		0	415
D6211	pontic – cast predominantly base metal		0	375

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		SPECIALTY REFERRAL:	PRE-AUTH	
		Agreement ID:	SCFG00000286	
CDT Code	Description		Copayment	Minimum Guarantee
D6212	pontic – cast noble metal		0	405
D6214	pontic – titanium		0	415
D6240	pontic – porcelain fused to high noble metal		0	415
D6241	pontic – porcelain fused to predominantly base metal		0	375
D6242	pontic – porcelain fused to noble metal		0	405
D6245	pontic – porcelain/ceramic		0	415
D6250	pontic – resin with high noble metal		0	415
D6251	pontic – resin with predominantly base metal		0	405
D6252	pontic – resin with noble metal		0	405
D6600	retainer inlay – porcelain/ceramic, two surfaces		0	310
D6601	retainer inlay – porcelain/ceramic, three or more surfaces		0	325
D6602	retainer inlay – cast high noble metal, two surfaces		0	270
D6603	retainer inlay – cast high noble metal, three or more surfaces		0	285
D6604	retainer inlay – cast predominantly base metal, two surfaces		0	260
D6605	retainer inlay – cast predominantly base metal, three or more surfaces		0	275
D6606	retainer inlay – cast noble metal, two surfaces		0	260
D6607	retainer inlay – cast noble metal, three or more surfaces		0	280
D6608	retainer onlay – porcelain/ceramic, two surfaces		0	275
D6609	retainer onlay – porcelain/ceramic, three or more surfaces		0	280
D6610	retainer onlay – cast high noble metal, two surfaces		0	415
D6611	retainer onlay – cast high noble metal, three or more surfaces		0	415
D6612	retainer onlay – cast predominantly base metal, two surfaces		0	375
D6613	retainer onlay – cast predominantly base metal, three or more surfaces		0	375
D6614	retainer onlay – cast noble metal, two surfaces		0	405
D6615	retainer onlay – cast noble metal, three or more surfaces		0	405
D6624	retainer inlay – titanium		0	270
D6634	retainer onlay – titanium		0	280
D6710	retainer crown – indirect resin based composite		0	195
D6720	retainer crown – resin with high noble metal		0	415
D6721	retainer crown – resin with predominantly base metal		0	405
D6722	retainer crown – resin with noble metal		0	405
D6740	retainer crown – porcelain/ceramic		0	415
D6750	retainer crown – porcelain fused to high noble metal		0	415
D6751	retainer crown – porcelain fused to predominantly base metal		0	375
D6752	retainer crown – porcelain fused to noble metal		0	405
D6780	retainer crown – ¾ cast high noble metal		0	415

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		SPECIALTY REFERRAL:	PRE-AUTH	
		Agreement ID:	SCFG00000286	
CDT Code	Description		Copayment	Minimum Guarantee
D6781	retainer crown – ¾ cast predominantly base metal		0	375
D6782	retainer crown – ¾ cast noble metal		0	405
D6783	retainer crown – ¾ porcelain/ceramic		0	415
D6790	retainer crown – full cast high noble metal		0	415
D6791	retainer crown – full cast predominantly base metal		0	375
D6792	retainer crown – full cast noble metal		0	405
D6794	retainer crown – titanium		0	415
D6930	re-cement or re-bond fixed partial denture		0	53
D6940	stress breaker		0	130
D6980	fixed partial denture repair necessitated by restorative material failure		0	65
X. ORAL AND MAXILLOFACIAL SURGERY				
D7111	extraction, coronal remnants – primary tooth		0	20
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)		0	70
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		0	75
D7220	removal of impacted tooth – soft tissue		0	75
D7230	removal of impacted tooth – partially bony		0	75
D7240	removal of impacted tooth – completely bony		0	165
D7241	removal of impacted tooth – completely bony, with unusual surgical complications		0	180
D7250	removal of residual tooth roots (cutting procedure)		0	175
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth		0	75
D7280	exposure of an unerupted tooth		0	135
D7282	mobilization of erupted or malpositioned tooth to aid eruption		0	145
D7285	incisional biopsy of oral tissue – hard (bone, tooth)		0	90
D7286	incisional biopsy of oral tissue – soft		0	60
D7288	brush biopsy – transepithelial sample collection		0	5
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		0	55
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		0	45
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		0	80
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		0	70
D7410	excision of benign lesion up to 1.25 cm		0	195
D7411	excision of benign lesion greater than 1.25 cm		0	400
D7412	excision of benign lesion, complicated		0	415
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm		0	230
D7451	removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm		0	335
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm		0	230
D7461	removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm		0	335

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		SPECIALTY REFERRAL:	PRE-AUTH	
		Agreement ID:	SCFG00000286	
CDT Code	Description		Copayment	Minimum Guarantee
D7471	removal of lateral exostosis (maxilla or mandible)		0	195
D7472	removal of torus palatinus		0	350
D7473	removal of torus mandibularis		0	315
D7485	reduction of osseous tuberosity		0	85
D7510	incision and drainage of abscess – intraoral soft tissue		0	25
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		0	40
D7520	incision and drainage of abscess – extraoral soft tissue		0	325
D7521	incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		0	400
D7881	occlusal orthotic device adjustment		0	30
D7910	suture of recent small wounds up to 5 cm		0	40
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure		0	30
D7963	frenuloplasty		0	60
D7970	excision of hyperplastic tissue – per arch		0	70
D7971	excision of pericoronal gingiva		0	60
D7972	surgical reduction of fibrous tuberosity		0	150
D7999	unspecified oral surgery procedure, by report		0	15
XII. ADJUNCTIVE GENERAL SERVICES				
D9110	palliative (emergency) treatment of dental pain – minor procedure		0	15
D9210	local anesthesia not in conjunction with operative or surgical procedures		0	10
D9211	regional block anesthesia		0	10
D9212	trigeminal division block anesthesia		0	15
D9215	local anesthesia in conjunction with operative or surgical procedures		0	10
D9222	deep sedation/general anesthesia – first 15 minutes		0	250
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment		0	125
D9230	inhalation of nitrous oxide/anxiolysis, analgesia		0	20
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes		0	160
D9243	intravenous moderate (conscious) sedation/anesthesia – each subsequent 15 minute increment		0	80
D9248	non-intravenous conscious sedation		0	25
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		0	25
D9311	consultation with a medical health care professional		0	25
D9430	office visit for observation (during regularly scheduled hours) – no other services performed		0	25
D9440	office visit – after regularly scheduled hours		0	40
D9450	case presentation, detailed and extensive treatment planning		0	0
D9930	treatment of complications (post-surgical) – unusual circumstances, by report		0	0
D9943	occlusal guard adjustment		0	30
D9944	occlusal guard – hard appliance, full arch		0	185

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		SPECIALTY REFERRAL:	PRE-AUTH	
		Agreement ID:	SCFG00000286	
CDT Code	Description		Copayment	Minimum Guarantee
D9945	occlusal guard – soft appliance, full arch		0	185
D9946	occlusal guard – hard appliance, partial arch		0	93
D9951	occlusal adjustment – limited		0	60
D9952	occlusal adjustment – complete		0	175
D9972	external bleaching – per arch – performed in office		0	125
D9995	teledentistry – synchronous; real-time encounter		0	0
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review		0	0
XI. ORTHODONTICS (Medically Necessary Banded Case)				
D8070	comprehensive orthodontic treatment of the transitional dentition		0	
D8080	comprehensive orthodontic treatment of the adolescent dentition		0	
D8090	comprehensive orthodontic treatment of the adult dentition		0	
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))		0	
D8690	orthodontic treatment (alternative billing to a contract fee)		0	
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment		0	
D8999	start up fee (including exam, beginning records, x-ray, tracings, photos and models) construction replacement of retainers		0	
D8999	post treatment records		0	
D8999	monthly orthodontic fee (for comprehensive treatment beyond 24 months)		0	

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.

EXHIBIT 2

EXCLUSION OF BENEFITS

Except as may be specifically provided in the Schedule of Covered Dental Services or through a Rider to the Group Agreement, the following are not Covered:

1. Dental Services that are not Necessary.
2. Costs for non-Dental Services related to the provision of Dental Services in hospitals, extended care facilities, or Subscriber's home. When deemed Necessary by the Primary Care Dentist, the Subscriber's Physician and authorized by us, Covered Dental Services that are delivered in an inpatient or outpatient hospital setting are Covered as indicated in the Schedule of Covered Dental Services.
3. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a participating dental setting. This will not apply to Covered Emergency Dental Services.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Placement of dental implants, implant-supported abutments and prosthesis.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Member by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. 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.
13. Replacement of complete dentures, 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.
14. 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 for the temporomandibular joint.
15. Expenses for dental procedures begun prior to the Member becoming enrolled under the Group Agreement.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Services rendered by a provider who is a member of a Member's family, including spouse, brother, sister, parent or child.
22. Dental Services otherwise Covered under the Group Agreement, but rendered after the date individual Coverage under the Group Agreement terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Group Agreement terminates.
23. Orthodontic Services unless deemed medically necessary.
24. Foreign Services are not Covered unless required as an Emergency.

HEALTH NET OF CA EHB AND EHB TRIBAL DHMO PLANS

LIMITATIONS AND EXCLUSIONS OF BENEFITS



EXHIBIT 2

25. 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.
26. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
27. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
28. Any Member 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.
29. Cephalometric x-rays
30. Treatment which requires the services of a pediatric specialist, after the Member's 6th birthday.
31. Consultations for non-Covered services.
32. A service started but not completed prior to the Member's eligibility to receive benefits under the plan. Inlays, onlays and fixed bridges are considered started when the tooth or teeth are prepared. Root canal treatment is considered started when the pulp chamber is opened. Orthodontics are considered started at the time of initial banding. Dentures are considered started when the impressions are taken.
33. A service started (as defined above) by a Non-Participating Dentist. This will not apply to Covered Emergency Dental Services.
34. Procedures performed to facilitate non-Covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
35. 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.

LIMITATION 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. BITEWING RADIOGRAPHS - Limited to 2 series of films per calendar year.
2. INTRAORAL - COMPLETE SERIES (INCLUDING BITEWINGS) - Limited to 1 time per consecutive 24 months.
3. PANORAMIC FILM - Limited to 1 time per consecutive 24 months
4. DENTAL PROPHYLAXIS - Adult and Child - Limited to 2 time per consecutive 12 months.
5. SEALANTS - Once per first or second permanent molar.
6. PERIODONTAL MAINTENANCE - Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
7. PERIODONTAL SCALING AND ROOT PLANNING - Limited to 5 quadrant treatment per consecutive 12 months.
8. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS PREVIOUSLY SUBMITTED FOR PAYMENT UNDE THE PLAN - Limited to 1 time per consecutive 36 months.
9. OFFICE OR LABORATORY REBASES AND RELINES - Limited to 1 time per consecutive 12 months.
10. TISSUE CONDITIONING - Limited to 2 times per denture.
11. PALLIATIVE TREATMENT - Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
12. OCCLUSAL GUARDS - Limited to 1 guard every consecutive 36 months.
13. EXTERNAL BLEACHING - PER ARCH - Limited to 1 per arch per consecutive 36 month

MEDICALLY NECESSARY ORTHODONTICS

Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized.

OPTIONAL, UPGRADED OR ALTERNATIVE TREATMENT DISCLOSURE FORM

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