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

UnitedHealthcare

| | |
|---|---|
| **Client Name on Capitation Roster:** | **HEALTH NET, INC - CALIFORNIA<br>CENTENE** |
| **Website:**<br>Offers eligibility verification, claim status and network specialist locations. | www.uhcdental.com |
| **Using our website to locate Dentists including Specialists:**<br>Before Log in, select "Provider Search", "State", and "Select A Network". | **HEALTH NET DHMO CA ONLY** |
| **Specialty Referral Process:**<br>**Pre-Authorization:** General Dentist must obtain preauthorization for all specialty services.<br>**Direct Referral:** General Dentist may directly refer a patient to any participating specialist.<br>**Self Referral:** Member may self-refer to any participating specialist. | Pre-Authorization,<br>Direct or<br>Self Referral<br>(Refer to copay schedule) |
| **Member ID Cards:**<br>The following brand names are found on the member id cards for your reference. | Health Net |
| **Integrated Voice Response (IVR) System:**<br>• Enables you to access information 24 hours a day<br>• Obtain real-time eligibility, eligibility via fax, and assign members to your office<br>• Obtain claim status and copies of EOB's | **1-866-249-2382** |
| **Dedicated Toll Free Customer Service:**<br>Issues such as eligibility, claims and dental plan information. | **1-866-249-2382** |
| **Provider Relations:**<br>Questions regarding fee schedules, monthly rosters and contracts | **1-866-249-2382** |
| **Emergency Specialty Referral Phone Number:** | **1-866-249-2382** |
| **Address:**<br>Encounter Data, Minimum Guarantee/Supplemental Claims | **P.O. Box 30567<br>Salt Lake City, UT 84130-0567** |
| Specialty Referral and Pre-Treatment Estimates | **P.O. Box 30552<br>Salt Lake City, UT 84130-0552** |
| Written Inquiries and Appeals | **P.O. Box 30569<br>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:**<br>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.**

**HEALTH NET OF CALIFORNIA / CENTENE DHMO**
**CAPITATION CROSSWALK / PER MEMBER-PER MONTH (PMPM)**
**EXHIBIT 2-A-ii**

UnitedHealthcare

| 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 |

**HEALTH NET OF CALIFORNIA / CENTENE DHMO**
**CAPITATION CROSSWALK / PER MEMBER-PER MONTH (PMPM)**
**EXHIBIT 2-A-ii**

UnitedHealthcare

| 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<br>Health Net of CA | EHB Tribal DHMO | E0005356<br>E0005360<br>E0005362<br>E0005364 | SCFG00000286 | $0.00 (Adult)<br>$2.45 (Child 0-19) | Yes | Pre-Auth | EHB |
| Centene<br>Health Net of CA | EHB DHMO | All other "E" Product ID's "E000XXXX" | SCFG00000284 | $0.00 (Adult)<br>$2.45 (Child 0-19) | Yes | Pre-Auth | EHB |

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

UnitedHealthcare®

| CDT CODE | Agreement ID: | Minimum Guarantee | HN Value DHMO 50 | HN Value DHMO 85 | HN Value DHMO 115 | HN Value DHMO 150 | HN Value DHMO 175 | HN Value DHMO 225 | HN Value DHMO 275 | HN Value 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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**EXHIBIT 2 - PART I**

UnitedHealthcare

| CDT CODE | Agreement ID: | Minimum Guarantee | HN Value DHMO 50 | HN Value DHMO 85 | HN Value DHMO 115 | HN Value DHMO 150 | HN Value DHMO 175 | HN Value DHMO 225 | HN Value DHMO 275 | HN Value 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 |
| 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 |



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**HEALTH NET OF CA DHMO**
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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 |



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

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

UnitedHealthcare

| CDT CODE | Agreement ID: | Minimum Guarantee | HN Value DHMO 50 | HN Value DHMO 85 | HN Value DHMO 115 | HN Value DHMO 150 | HN Value DHMO 175 | HN Value DHMO 225 | HN Value DHMO 275 | HN Value 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 |



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

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

UnitedHealthcare

| CDT CODE | Agreement ID: | Minimum Guarantee | HN Value DHMO 50 SCFG00000189 | HN Value DHMO 85 SCFG00000190 | HN Value DHMO 115 SCFG00000191 | HN Value DHMO 150 SCFG00000192 | HN Value DHMO 175 SCFG00000193 | HN Value DHMO 225 SCFG00000194 | HN Value DHMO 275 SCFG00000195 | HN Value DHMO 115 (UC Post) 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART I**

UnitedHealthcare®

| CDT CODE | Agreement ID: | Minimum Guarantee | HN Value DHMO 50 | HN Value DHMO 85 | HN Value DHMO 115 | HN Value DHMO 150 | HN Value DHMO 175 | HN Value DHMO 225 | HN Value DHMO 275 | HN Value 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 |
| 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART I**

UnitedHealthcare®

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|---|---|---|---|---|---|---|---|---|---|---|
| | | | SCFG00000189 | SCFG00000190 | SCFG00000191 | SCFG00000192 | SCFG00000193 | SCFG00000194 | SCFG00000195 | SCFG00000221 |
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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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART I**

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|---|---|---|---|---|---|---|---|---|---|---|
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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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**HEALTH NET OF CA DHMO**
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**EXHIBIT 2 - PART I**

UnitedHealthcare

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| | | | SCFG00000189 | SCFG00000190 | SCFG00000191 | SCFG00000192 | SCFG00000193 | SCFG00000194 | SCFG00000195 | SCFG00000221 |
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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 |



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**HEALTH NET OF CA DHMO**
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**EXHIBIT 2 - PART I**

UnitedHealthcare®

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

UnitedHealthcare®

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|---|---|---|---|---|---|---|---|---|---|---|
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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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UnitedHealthcare

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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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**EXHIBIT 2 - PART I**

UnitedHealthcare®

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

UnitedHealthcare

| CDT CODE | Agreement ID: | Minimum Guarantee | HN Value DHMO 50 | HN Value DHMO 85 | HN Value DHMO 115 | HN Value DHMO 150 | HN Value DHMO 175 | HN Value DHMO 225 | HN Value DHMO 275 | HN Value 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 |
| 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART I**

| CDT CODE | Agreement ID: | Minimum Guarantee | HN Value DHMO 50 | HN Value DHMO 85 | HN Value DHMO 115 | HN Value DHMO 150 | HN Value DHMO 175 | HN Value DHMO 225 | HN Value DHMO 275 | HN Value 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART I**

| CDT CODE | Agreement ID: | Minimum Guarantee | HN Value DHMO 50 | HN Value DHMO 85 | HN Value DHMO 115 | HN Value DHMO 150 | HN Value DHMO 175 | HN Value DHMO 225 | HN Value DHMO 275 | HN Value 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 |
| 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 reline 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART I**

UnitedHealthcare®

| CDT CODE | Agreement ID: | Minimum Guarantee | HN Value DHMO 50 SCFG00000189 | HN Value DHMO 85 SCFG00000190 | HN Value DHMO 115 SCFG00000191 | HN Value DHMO 150 SCFG00000192 | HN Value DHMO 175 SCFG00000193 | HN Value DHMO 225 SCFG00000194 | HN Value DHMO 275 SCFG00000195 | HN Value DHMO 115 (UC Post) 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 |
| 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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## HEALTH NET OF CA DHMO
## PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
## EXHIBIT 2 - PART I

| CDT CODE | Agreement ID: | Minimum Guarantee | HN Value DHMO 50 | HN Value DHMO 85 | HN Value DHMO 115 | HN Value DHMO 150 | HN Value DHMO 175 | HN Value DHMO 225 | HN Value DHMO 275 | HN Value 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 |
| 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 | $100 |





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

# HEALTH NET OF CA DHMO
# LIMITATIONS AND EXCLUSIONS OF BENEFITS
# 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.

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

UnitedHealthcare®

| 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 |
|---|---|---|---|---|---|---|---|---|
| | Agreement ID: | | 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART II**

UnitedHealthcare®

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN Plus DHMO 85 SCFG00000196 | HN Plus DHMO 100 SCFG00000197 | HN Plus DHMO 150 SCFG00000198 | HN Plus DHMO 185 SCFG00000199 | HN Plus DHMO 225 SCFG00000200 | HN FB DHMO Preferred SCFG00000202 |
|---|---|---|---|---|---|---|---|---|
| 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART II**

UnitedHealthcare®

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN Plus DHMO 85 SCFG00000196 | HN Plus DHMO 100 SCFG00000197 | HN Plus DHMO 150 SCFG00000198 | HN Plus DHMO 185 SCFG00000199 | HN Plus DHMO 225 SCFG00000200 | HN FB DHMO Preferred SCFG00000202 |
|---|---|---|---|---|---|---|---|---|
| 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**<br>**• 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.**<br>**• 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART II**

UnitedHealthcare®

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN Plus DHMO 85 SCFG00000196 | HN Plus DHMO 100 SCFG00000197 | HN Plus DHMO 150 SCFG00000198 | HN Plus DHMO 185 SCFG00000199 | HN Plus DHMO 225 SCFG00000200 | HN FB DHMO Preferred SCFG00000202 |
|---|---|---|---|---|---|---|---|---|
| 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART II**

UnitedHealthcare®

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN Plus DHMO 85 SCFG00000196 | HN Plus DHMO 100 SCFG00000197 | HN Plus DHMO 150 SCFG00000198 | HN Plus DHMO 185 SCFG00000199 | HN Plus DHMO 225 SCFG00000200 | HN FB DHMO Preferred SCFG00000202 |
|---|---|---|---|---|---|---|---|---|
| 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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**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 SCFG00000196 | HN Plus DHMO 100 SCFG00000197 | HN Plus DHMO 150 SCFG00000198 | HN Plus DHMO 185 SCFG00000199 | HN Plus DHMO 225 SCFG00000200 | HN FB DHMO Preferred SCFG00000202 |
|---|---|---|---|---|---|---|---|---|
| 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART II**

UnitedHealthcare®

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN Plus DHMO 85 SCFG00000196 | HN Plus DHMO 100 SCFG00000197 | HN Plus DHMO 150 SCFG00000198 | HN Plus DHMO 185 SCFG00000199 | HN Plus DHMO 225 SCFG00000200 | HN FB DHMO Preferred SCFG00000202 |
|---|---|---|---|---|---|---|---|---|
| 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART II**

UnitedHealthcare®

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN Plus DHMO 85 SCFG00000196 | HN Plus DHMO 100 SCFG00000197 | HN Plus DHMO 150 SCFG00000198 | HN Plus DHMO 185 SCFG00000199 | HN Plus DHMO 225 SCFG00000200 | HN FB DHMO Preferred SCFG00000202 |
|---|---|---|---|---|---|---|---|---|
| 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART II**

UnitedHealthcare®

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN Plus DHMO 85 SCFG00000196 | HN Plus DHMO 100 SCFG00000197 | HN Plus DHMO 150 SCFG00000198 | HN Plus DHMO 185 SCFG00000199 | HN Plus DHMO 225 SCFG00000200 | HN FB DHMO Preferred SCFG00000202 |
|---|---|---|---|---|---|---|---|---|
| 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART II**

UnitedHealthcare®

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN Plus DHMO 85 SCFG00000196 | HN Plus DHMO 100 SCFG00000197 | HN Plus DHMO 150 SCFG00000198 | HN Plus DHMO 185 SCFG00000199 | HN Plus DHMO 225 SCFG00000200 | HN FB DHMO Preferred SCFG00000202 |
|---|---|---|---|---|---|---|---|---|
| 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART II**

UnitedHealthcare®

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN Plus DHMO 85 SCFG00000196 | HN Plus DHMO 100 SCFG00000197 | HN Plus DHMO 150 SCFG00000198 | HN Plus DHMO 185 SCFG00000199 | HN Plus DHMO 225 SCFG00000200 | HN FB DHMO Preferred SCFG00000202 |
|---|---|---|---|---|---|---|---|---|
| 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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**HEALTH NET OF CA DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART II**

UnitedHealthcare®

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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** | | | | | | | | |
| • **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 |



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

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|---|---|---|---|---|---|---|---|---|
| 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**<br>• **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 |



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**EXHIBIT 2 - PART II**

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|---|---|---|---|---|---|---|---|---|
| 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 |



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**EXHIBIT 2 - PART II**

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|---|---|---|---|---|---|---|---|---|
| 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 |



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|---|---|---|---|---|---|---|---|---|
| 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 |





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# 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.

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

UnitedHealthcare

| 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 |



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

UnitedHealthcare

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN FB DHMO SCFG00000201 | HN Group Plan 90-SD SCFG00000203 | HN GEMINI DHMO 50-S SCFG00000205 | HN IFP DHMO Adult Buy Up 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 |



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

UnitedHealthcare

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN FB DHMO SCFG00000201 | HN Group Plan 90-SD SCFG00000203 | HN GEMINI DHMO 50-S SCFG00000205 | HN IFP DHMO Adult Buy Up SCFG00000206 |
|---|---|---|---|---|---|---|
| **III. RESTORATIVE** | | | | | | |
| • 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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**HEALTH NET OF CA / CENTENE DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART III**

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN FB DHMO SCFG00000201 | HN Group Plan 90-SD SCFG00000203 | HN GEMINI DHMO 50-S SCFG00000205 | HN IFP DHMO Adult Buy Up 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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**HEALTH NET OF CA / CENTENE DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART III**

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN FB DHMO SCFG00000201 | HN Group Plan 90-SD SCFG00000203 | HN GEMINI DHMO 50-S SCFG00000205 | HN IFP DHMO Adult Buy Up SCFG00000206 |
|---|---|---|---|---|---|---|
| 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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**HEALTH NET OF CA / CENTENE DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART III**

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN FB DHMO SCFG00000201 | HN Group Plan 90-SD SCFG00000203 | HN GEMINI DHMO 50-S SCFG00000205 | HN IFP DHMO Adult Buy Up SCFG00000206 |
|---|---|---|---|---|---|---|
| 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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**HEALTH NET OF CA / CENTENE DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART III**

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN FB DHMO SCFG00000201 | HN Group Plan 90-SD SCFG00000203 | HN GEMINI DHMO 50-S SCFG00000205 | HN IFP DHMO Adult Buy Up SCFG00000206 |
|---|---|---|---|---|---|---|
| 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 |

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

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

UnitedHealthcare

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN FB DHMO SCFG00000201 | HN Group Plan 90-SD SCFG00000203 | HN GEMINI DHMO 50-S SCFG00000205 | HN IFP DHMO Adult Buy Up SCFG00000206 |
|---|---|---|---|---|---|---|
| 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**<br>• **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.**<br>• **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 |



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

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

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN FB DHMO SCFG00000201 | HN Group Plan 90-SD SCFG00000203 | HN GEMINI DHMO 50-S SCFG00000205 | HN IFP DHMO Adult Buy Up SCFG00000206 |
|---|---|---|---|---|---|---|
| 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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**HEALTH NET OF CA / CENTENE DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART III**

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN FB DHMO SCFG00000201 | HN Group Plan 90-SD SCFG00000203 | HN GEMINI DHMO 50-S SCFG00000205 | HN IFP DHMO Adult Buy Up SCFG00000206 |
|---|---|---|---|---|---|---|
| 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 |

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

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

| CDT CODE | Plan Name: / Agreement ID: | Minimum Guarantee | HN FB DHMO SCFG00000201 | HN Group Plan 90-SD SCFG00000203 | HN GEMINI DHMO 50-S SCFG00000205 | HN IFP DHMO Adult Buy Up 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 |





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

# HEALTH NET OF CA / CENTENE DHMO
# LIMITATIONS AND EXCLUSIONS OF BENEFITS
# 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.

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

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## 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.

# 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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## 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 birthdate, 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 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 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 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 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.

# HEALTH NET OF CA / CENTENE DHMO
# LIMITATIONS AND EXCLUSIONS OF BENEFITS
# 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. Tempormandibular 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.

## 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.

## 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.

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

| CDT CODE | Plan Name: | 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 |
|---|---|---|---|---|---|
| | Agreement ID: | 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 Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp SCFG00000208 | HN Custom CV DHMO Grp Ret SCFG00000211 | Boeing DHMO Buy Up Group SCFG00000219 |
|---|---|---|---|---|---|
| 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**

UnitedHealthcare

| CDT CODE | Plan Name: / Agreement ID: | HN Buy Up Group / HN DHMO Group Med Supp Buy Up SCFG00000207 | HN DHMO Medicare Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp SCFG00000208 | HN Custom CV DHMO Grp Ret SCFG00000211 | Boeing DHMO Buy Up Group 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** | | | | | |
| • **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 |

**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 Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp SCFG00000208 | HN Custom CV DHMO Grp Ret SCFG00000211 | Boeing DHMO Buy Up Group SCFG00000219 |
|---|---|---|---|---|---|
| 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 |

**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 Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp SCFG00000208 | HN Custom CV DHMO Grp Ret SCFG00000211 | Boeing DHMO Buy Up Group SCFG00000219 |
|---|---|---|---|---|---|
| **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/calcific 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/calcific 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 |

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

UnitedHealthcare

| CDT CODE | Plan Name: / Agreement ID: | HN Buy Up Group / HN DHMO Group Med Supp Buy Up SCFG00000207 | HN DHMO Medicare Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp SCFG00000208 | HN Custom CV DHMO Grp Ret SCFG00000211 | Boeing DHMO Buy Up Group 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 |

**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 Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp SCFG00000208 | HN Custom CV DHMO Grp Ret SCFG00000211 | Boeing DHMO Buy Up Group SCFG00000219 |
|---|---|---|---|---|---|
| **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 |

**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<br>SCFG00000207 | HN DHMO Medicare Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp<br>SCFG00000208 | HN Custom CV DHMO Grp Ret<br>SCFG00000211 | Boeing DHMO Buy Up Group<br>SCFG00000219 |
|---|---|---|---|---|---|
| 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 |

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

UnitedHealthcare

| CDT CODE | Plan Name: / Agreement ID: | HN Buy Up Group / HN DHMO Group Med Supp Buy Up SCFG00000207 | HN DHMO Medicare Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp SCFG00000208 | HN Custom CV DHMO Grp Ret SCFG00000211 | Boeing DHMO Buy Up Group SCFG00000219 |
|---|---|---|---|---|---|
| **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 |

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

UnitedHealthcare

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|---|---|---|---|---|---|
| **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 |

**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 Supp Buy Up / HN Supp Buy Up Ruby / HN Supp Buy Up Salud / HN SNP RMC DHMO Supp SCFG00000208 | HN Custom CV DHMO Grp Ret SCFG00000211 | Boeing DHMO Buy Up Group SCFG00000219 |
|---|---|---|---|---|---|
| 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 | 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 |
| D9999 | 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 |

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

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|---|---|---|---|---|---|
| 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 |

# 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.

# 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

### 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.

**HEALTH NET OF CA / CENTENE DHMO**
**JADE, AMBER SNP CHF CORE, MEDICARE DHMO & EHB DHMO Plans**

UnitedHealthcare

| 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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**HEALTH NET OF CA / CENTENE DHMO**
**JADE, AMBER SNP CHF CORE, MEDICARE DHMO & EHB DHMO Plans**

UnitedHealthcare

| 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 |
| 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** | | | | | |
| • **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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|---|---|---|---|---|---|
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| | 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 |

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| 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 |

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| 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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| 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: eposteal 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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| 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 |



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

**HEALTH NET OF CA / CENTENE DHMO**
**JADE, AMBER SNP CHF CORE, MEDICARE DHMO & EHB DHMO Plans**

UnitedHealthcare

| 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 |
| 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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**HEALTH NET OF CA / CENTENE DHMO**
**JADE, AMBER SNP CHF CORE, MEDICARE DHMO & EHB DHMO Plans**

UnitedHealthcare

| 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 |
| 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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**HEALTH NET OF CA / CENTENE DHMO**
**JADE, AMBER SNP CHF CORE, MEDICARE DHMO & EHB DHMO Plans**

UnitedHealthcare

| 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 |
| 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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**HEALTH NET OF CA / CENTENE DHMO**
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UnitedHealthcare

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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 |
| 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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**HEALTH NET OF CA / CENTENE DHMO**
**JADE, AMBER SNP CHF CORE, MEDICARE DHMO & EHB DHMO Plans**

UnitedHealthcare

| 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 |
| 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 | |





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

## 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 |

# HEALTH NET OF CA AND CENTENE (JADE, AMBER CORE AND MEDICARE) DHMO PLANS
# LIMITATIONS AND EXCLUSIONS OF BENEFITS
# EXHIBIT 2

UnitedHealthcare®

## 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.

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

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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**Customer Service Phone Number 1-866-249-2382**

| | | 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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| 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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| 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 |



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

UnitedHealthcare

| Customer Service Phone Number 1-866-249-2382 | | | |
|---|---|---|---|
| | 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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UnitedHealthcare

**Customer Service Phone Number 1-866-249-2382**

| | | 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 |



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

UnitedHealthcare

**Customer Service Phone Number 1-866-249-2382**

| | | |
|---|---|---|
| | **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 | |





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

# HEALTH NET OF CA EHB AND EHB TRIBAL DHMO PLANS
# LIMITATIONS AND EXCLUSIONS OF BENEFITS
# 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.

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 PREVIUOSLY 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: | UnitedHealthcare |
|---|---|---|
| Treatment Plan No.: | | Chart ID No.: |

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

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

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

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

*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: |