





	<b>UnitedHealthcare</b>	<b>Lincoln Financial Group (Lincoln Dental Connect)</b>	<b>AARP Medicare Complete (Secure Horizons)</b>	<b>UHC Pacificare &amp; UHC Dental Individual Membership</b>
<b>Client Name on Capitation Roster:</b>	USS UHC West UnitedHealthcare	Lincoln Financial Group	Ovations	UnitedHealthcare UHC Dental Individual Membership
<b>Website:</b> Offers eligibility verification, claim status and network specialist locations.	<b>www.uhcdental.com</b>			
<b>Using our website to locate Dentists including Specialists:</b> Before Log in, select "Provider Search", "State", and "Select A Network".	CA DHMO Plan CA DHMO Pediatric EHB & Family Buy Up		CA DHMO AARP MEDICARE COMPLETE	CA DHMO-LEGACY PACIFICARE
<b>Specialty Referral Process:</b>	PRE-AUTHORIZATION			
<b>Member ID Cards:</b> The following brand names are found on the member ID cards for your reference.				
<b>Integrated Voice Response (IVR) System</b> <ul style="list-style-type: none"> <li>Enables you to access information 24 hours a day</li> <li>Obtain real-time eligibility, eligibility via fax, and assign members to your office</li> <li>Obtain claim status and copies of EOB's</li> </ul>	<b>1-877-732-4337</b>	<b>1-888-877-7828</b>	<b>1-877-732-4337</b>	<b>1-877-732-4337</b>
<b>Dedicated Toll Free Customer Service:</b> Issues such as eligibility, claims and dental plan information.	<b>1-877-732-4337</b>	<b>1-888-877-7828</b>	<b>1-877-732-4337</b>	<b>1-877-732-4337</b>
<b>Provider Relations:</b> Questions regarding fee schedules, monthly rosters and contracts	<b>1-877-732-4337</b>	<b>1-888-877-7828</b>	<b>1-877-732-4337</b>	<b>1-877-732-4337</b>
<b>Emergency Specialty Referral Phone Number:</b>	<b>1-877-732-4337</b>	<b>1-888-877-7828</b>	<b>1-877-732-4337</b>	<b>1-877-732-4337</b>
<b>Request for Specialty Referral Form and Provider Manual:</b>	<b>1-877-732-4337</b>	<b>1-888-877-7828</b>	<b>1-877-732-4337</b>	<b>1-877-732-4337</b>
<b>Address:</b> Encounter Data/Minimum Guarantee/Supplemental Claims	P.O. Box 30567 Salt Lake City, UT 84130-0567			
<b>Address:</b> Specialty Referral and Pre-Treatment Estimates	P.O. Box 30552 Salt Lake City, UT 84130-0552			
<b>Address:</b> Written Inquiries and Appeals	P.O. Box 30569 Salt Lake City, UT 84130-0569			
<b>Electronic Claims Submission - Payor ID:</b>	<b>52133</b>			
<b>California Language Assistance Program:</b> If language assistance is required, contact UHC at the number provided on the back of the member's ID Card. You will be connected with the Language Line, via a customer service representative, where certified interpreters are available to provide telephonic interpretation services.				
<b>Benefits for the UnitedHealthcare Dental DHMO/Direct Compensation plans are offered by Dental Benefit Providers of California, Inc. UnitedHealthcare Dental is affiliated with UnitedHealthcare.</b>				
All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.				

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



**Dental Benefit  
 Providers of California**

**EXHIBIT 2-A-V**

Product ID	Product Name / Client Name	Plan Name / Copayment Schedule	Agreement ID	PMPM Capitation Rate	Minimum Guarantee	Supplemental	Specialty Referral Process	Plan Type
D0010675	UnitedHealthcare - Lincoln Financial Group	Plan 450	DMOCARG00011	\$3.97	Yes	No	Pre-Auth	Commercial
D0010676	UnitedHealthcare - Lincoln Financial Group	Plan 450	DMOCARG00011	\$3.97	Yes	No	Pre-Auth	Commercial
D0010677	UnitedHealthcare - Lincoln Financial Group	Plan 450C	DMOCARG00005	\$3.75	Yes	No	Pre-Auth	Commercial
D0010678	UnitedHealthcare - Lincoln Financial Group	Plan 450C	DMOCARG00005	\$3.75	Yes	No	Pre-Auth	Commercial
D0010679	UnitedHealthcare - Lincoln Financial Group	Plan 550	DMOCARG00013	\$4.47	Yes	No	Pre-Auth	Commercial
D0010680	UnitedHealthcare - Lincoln Financial Group	Plan 550	DMOCARG00013	\$4.47	Yes	No	Pre-Auth	Commercial
D0010681	UnitedHealthcare - Lincoln Financial Group	Plan 550C	DMOCARG00008	\$4.25	Yes	No	Pre-Auth	Commercial
D0010682	UnitedHealthcare - Lincoln Financial Group	Plan 550C	DMOCARG00008	\$4.25	Yes	No	Pre-Auth	Commercial
D0010683	UnitedHealthcare - Lincoln Financial Group	Plan 650	DMOCARG00015	\$4.82	Yes	No	Pre-Auth	Commercial
D0010684	UnitedHealthcare - Lincoln Financial Group	Plan 650	DMOCARG00015	\$4.82	Yes	No	Pre-Auth	Commercial
D0010685	UnitedHealthcare - Lincoln Financial Group	Plan 650C	DMOCARG00009	\$4.60	Yes	No	Pre-Auth	Commercial
D0010686	UnitedHealthcare - Lincoln Financial Group	Plan 650C	DMOCARG00009	\$4.60	Yes	No	Pre-Auth	Commercial
D0010687	UnitedHealthcare - Lincoln Financial Group	Plan 750	DMOCARG00017	\$5.72	Yes	No	Pre-Auth	Commercial
D0010688	UnitedHealthcare - Lincoln Financial Group	Plan 750	DMOCARG00017	\$5.72	Yes	No	Pre-Auth	Commercial
D0010689	UnitedHealthcare - Lincoln Financial Group	Plan 750C	DMOCARG00002	\$5.50	Yes	No	Pre-Auth	Commercial
D0010690	UnitedHealthcare - Lincoln Financial Group	Plan 750C	DMOCARG00002	\$5.50	Yes	No	Pre-Auth	Commercial
D0010815	UnitedHealthcare	Pismo 140C	DMOCARG00007	\$4.45	Yes	No	Pre-Auth	Commercial
D0010842	UnitedHealthcare	Newport 120C	DMOCARG00004	\$3.85	Yes	No	Pre-Auth	Commercial
D0010844	UnitedHealthcare	Pismo 140C	DMOCARG00007	\$4.45	Yes	No	Pre-Auth	Commercial
D0010852	UnitedHealthcare	Malibu 130C	DMOCARG00003	\$4.12	Yes	No	Pre-Auth	Commercial
D0010859	UnitedHealthcare	Newport 120C	DMOCARG00004	\$3.85	Yes	No	Pre-Auth	Commercial
D0010881	UnitedHealthcare	Laguna 110	DMOCARG00010	\$3.75	Yes	No	Pre-Auth	Commercial
D0010897	UnitedHealthcare	Laguna 110C	DMOCARG00001	\$3.53	Yes	No	Pre-Auth	Commercial
D0010898	UnitedHealthcare	Pismo 140	DMOCARG00014	\$4.67	Yes	No	Pre-Auth	Commercial
D0010971	UnitedHealthcare	Santa Cruz 150	DMOCARG00016	\$5.47	Yes	No	Pre-Auth	Commercial
D0010981	UnitedHealthcare	Santa Cruz 150	DMOCARG00016	\$5.47	Yes	No	Pre-Auth	Commercial
D0010993	UnitedHealthcare	Santa Cruz 150C	DMOCARG00006	\$5.25	Yes	No	Pre-Auth	Commercial
D0010994	UnitedHealthcare	Santa Cruz 150C	DMOCARG00006	\$5.25	Yes	No	Pre-Auth	Commercial
D0010995	UnitedHealthcare	Laguna 110	DMOCARG00010	\$3.75	Yes	No	Pre-Auth	Commercial
D0010996	UnitedHealthcare	Laguna 110C	DMOCARG00001	\$3.53	Yes	No	Pre-Auth	Commercial
D0010997	UnitedHealthcare	Newport 120	DMOCARG00012	\$4.07	Yes	No	Pre-Auth	Commercial
D0010998	UnitedHealthcare	Newport 120	DMOCARG00012	\$4.07	Yes	No	Pre-Auth	Commercial
D0010999	UnitedHealthcare	Malibu 130C	DMOCARG00003	\$4.12	Yes	No	Pre-Auth	Commercial
D0011000	UnitedHealthcare	Pismo 140	DMOCARG00014	\$4.67	Yes	No	Pre-Auth	Commercial
D0011001	UnitedHealthcare	Malibu 130	DMOCARG00018	\$4.34	Yes	No	Pre-Auth	Commercial
D0011002	UnitedHealthcare	Malibu 130	DMOCARG00018	\$4.34	Yes	No	Pre-Auth	Commercial
D0012002	UnitedHealthcare (PacifiCare)	UHC DENTAL 160	SFSGD0000019	\$3.09	No	No	Pre-Auth - Ortho CDT Codes Only (No Specialty Benefit Except Ortho)	Commercial
D0012003	UnitedHealthcare (PacifiCare)	UHC DENTAL 161	SFSGD0000020	\$4.94	No	No	Pre-Auth	Commercial
D0012009	UnitedHealthcare (PacifiCare)	UHC DENTAL 100	SFSGD0000008	\$0.00	No	No	Pre-Auth - Ortho CDT Codes Only (No Specialty Benefit Except Ortho)	Commercial
D0012013	UnitedHealthcare (PacifiCare)	UHC DENTAL 132	SFSGD0000013	\$3.65	No	Yes	Pre-Auth	Commercial

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



**Dental Benefit  
Providers of California**

**EXHIBIT 2-A-V**

Product ID	Product Name / Client Name	Plan Name / Copayment Schedule	Agreement ID	PMPM Capitation Rate	Minimum Guarantee	Supplemental	Specialty Referral Process	Plan Type
D0012015	UnitedHealthcare (PacifiCare)	UHC DENTAL 140	SFSGD0000014	\$2.41	No	Yes	Pre-Auth	Commercial
D0012016	UnitedHealthcare (PacifiCare)	UHC DENTAL 142 FEDS	SFSGD0000016	\$3.65	No	Yes	Pre-Auth	Commercial
D0012017	UnitedHealthcare (PacifiCare)	UHC DENTAL 142	SFSGD0000007	\$3.42	No	Yes	Pre-Auth	Commercial
D0012018	UnitedHealthcare (PacifiCare)	UHC DENTAL 144	SFSGD0000003	\$3.83	No	Yes	Pre-Auth	Commercial
D0012020	UnitedHealthcare (PacifiCare)	UHC DENTAL 146	SFSGD0000018	\$4.80	No	Yes	Pre-Auth	Commercial
D0012023	AARP Medicare Complete Secure Horizons (Ovations)	SH100 Retiree	SFSGD0000002	\$0.00	No	Yes*	Not Covered	Medicare
D0012027	UnitedHealthcare (PacifiCare)	UHC 590H	SFSGD0000015	\$6.00	No	No	Pre-Auth	Commercial
D0012794	UnitedHealthcare	UHC AON Exchange CA DHMO Plan 130	DMOCARG00018	\$4.34	Yes	No	Pre-Auth	Commercial
D0018631	UnitedHealthcare	UHC AON Exchange CA DHMO Plan 130	DMOCARG00018	\$4.34	Yes	No	Pre-Auth	Commercial
D0023628	UnitedHealthcare	Malibu 130	DMOCARG00018	\$4.34	Yes	No	Pre-Auth	Commercial
D0025003	UnitedHealthcare	Santa Cruz 150	DMOCARG00016	\$5.47	Yes	No	Pre-Auth	Commercial
D0033496	UnitedHealthcare	Malibu 130C	DMOCARG00003	\$4.12	Yes	No	Pre-Auth	Commercial
All "E" Product IDs	UnitedHealthcare	UHC 2018 CA EHB DHMO UHC 2019 CA EHB DHMO	SCFG00000263 SCFG00000698	\$3.10 (Child 0-19)	Yes	No	Pre-Auth	EHB

\*Encounter Fee Supplemental Only

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

**UNITEDHEALTHCARE DHMO**  
**PRINCIPAL BENEFITS AND COVERAGES - MEMBER COPAYMENTS**  
**EXHIBIT 2 - PART I**



Customer Service Phone Number 1-877-732-4337		Plan Name Agreement ID	Laguna 110C	Newport 120C	Malibu 130C	Pismo 140C	Santa Cruz 150C
			DMOCARG00001	DMOCARG00004	DMOCARG00003	DMOCARG00007	DMOCARG00006
			Laguna 110	Newport 120	Malibu 130	Pismo 140	Santa Cruz 150
			DMOCARG00010	DMOCARG00012	DMOCARG00018	DMOCARG00014	DMOCARG00016
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
<b>I. DIAGNOSTIC</b>							
D0120	periodic oral evaluation – established patient		0	0	0	0	0
D0140	limited oral evaluation – problem focused		0	0	0	0	0
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver		0	0	0	0	0
D0150	comprehensive oral evaluation – new or established patient		0	0	0	0	0
D0160	detailed and extensive oral evaluation – problem focused, by report		0	0	0	0	0
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)		0	0	0	0	0
D0171	re-evaluation – post-operative office visit		5	5	5	5	5
D0180	comprehensive periodontal evaluation – new or established patient		0	0	0	0	0
D0190	screening of a patient		5	5	5	5	5
D0191	assessment of a patient		5	5	5	5	5
D0210	intraoral – complete series of radiographic images		0	0	0	0	0
D0220	intraoral – periapical first radiographic image		0	0	0	0	0
D0230	intraoral – periapical each additional radiographic image		0	0	0	0	0
D0240	intraoral – occlusal radiographic image		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
D0251	extra-oral posterior dental radiographic image		0	0	0	0	0
D0270	bitewing – single radiographic image		0	0	0	0	0
D0272	bitewings – two radiographic images		0	0	0	0	0
D0273	bitewings – three radiographic images		0	0	0	0	0
D0274	bitewings – four radiographic images		0	0	0	0	0
D0277	vertical bitewings – 7 to 8 radiographic images		0	0	0	0	0
D0330	panoramic radiographic image		5	0	0	0	0
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis		50	50	50	50	50
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw	85	55	45	40	30	20
D0365	cone beam CT capture and interpretation with field of view of one full dental arch – mandible	85	55	45	40	30	20
D0366	cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	95	65	50	45	35	25
D0367	cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	115	75	60	50	40	30
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report		5	5	5	5	5
D0411	HbA1c in-office point of service testing		10	10	10	10	10

<sup>1</sup> DBP will pay your office the difference between the Minimum Guarantee listed above and the Member's Copay.

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**EXHIBIT 2 - PART I**



Customer Service Phone Number 1-877-732-4337		Plan Name Agreement ID	Laguna 110C	Newport 120C	Malibu 130C	Pismo 140C	Santa Cruz 150C	
			DMOCARG00001	DMOCARG00004	DMOCARG00003	DMOCARG00007	DMOCARG00006	
			Laguna 110	Newport 120	Malibu 130	Pismo 140	Santa Cruz 150	
			DMOCARG00010	DMOCARG00012	DMOCARG00018	DMOCARG00014	DMOCARG00016	
CDT codes not listed are not a covered benefit			Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment					
D0412	blood glucose level test – in-office using a glucose meter		3	3	3	3	3	
D0414	laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report		0	0	0	0	0	
D0415	collection of microorganisms for culture and sensitivity		0	0	0	0	0	
D0416	viral culture		10	10	10	10	10	
D0417	collection and preparation of saliva sample for laboratory diagnostic testing		10	10	10	10	10	
D0418	analysis of saliva sample		10	10	10	10	10	
D0422	collection and preparation of genetic sample material for laboratory analysis and report		0	0	0	0	0	
D0423	genetic test for susceptibility to diseases – specimen analysis		0	0	0	0	0	
D0425	caries susceptibility tests		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	40	20	20	20	20	20	
D0460	pulp vitality tests		0	0	0	0	0	
D0470	diagnostic casts		12	0	0	0	0	
D0472	accession of tissue, gross examination, preparation and transmission of written report		0	0	0	0	0	
D0473	accession of tissue, gross and microscopic examination, preparation and transmission of written report		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	
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum		0	0	0	0	0	
D0601	caries risk assessment and documentation, with a finding of low risk		0	0	0	0	0	
D0602	caries risk assessment and documentation, with a finding of moderate risk		0	0	0	0	0	
D0603	caries risk assessment and documentation, with a finding of high risk		0	0	0	0	0	
D0999	Office visit fee - per visit *Member is responsible for \$5.00 office visit fee for Plan Name ending in "C" (e.g. Laguna 110C).	2	0/5 <sup>2</sup>	0/5 <sup>2</sup>	0/5 <sup>2</sup>	0/5 <sup>2</sup>	0/5 <sup>2</sup>	

<b>II. PREVENTIVE</b>							
<b>* Additional Prophylaxis within 6 months will be based upon the necessity recommended by the provider.</b>							
D1110	prophylaxis – adult		5	0	0	0	0
-----	prophylaxis - adult: Additional Prophylaxis within 6 months*		25	25	25	25	25
D1120	prophylaxis – child		5	0	0	0	0

<sup>1</sup> DBP will pay your office the difference between the Minimum Guarantee listed above and the Member's Copay.

**UNITEDHEALTHCARE DHMO**  
**PRINCIPAL BENEFITS AND COVERAGES - MEMBER COPAYMENTS**  
**EXHIBIT 2 - PART I**



Customer Service Phone Number 1-877-732-4337		Plan Name Agreement ID	Laguna 110C	Newport 120C	Malibu 130C	Pismo 140C	Santa Cruz 150C
			DMOCARG00001	DMOCARG00004	DMOCARG00003	DMOCARG00007	DMOCARG00006
			Laguna 110	Newport 120	Malibu 130	Pismo 140	Santa Cruz 150
			DMOCARG00010	DMOCARG00012	DMOCARG00018	DMOCARG00014	DMOCARG00016
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
-----	prophylaxis - child: Additional Prophy within 6 months*		25	25	25	25	25
D1206	topical application of fluoride varnish		5	0	0	0	0
D1208	topical application of fluoride – excluding varnish		0	0	0	0	0
D1310	nutritional counseling for control of dental disease		0	0	0	0	0
D1320	tobacco counseling for the control and prevention of oral disease		0	0	0	0	0
D1330	oral hygiene instructions		0	0	0	0	0
D1351	sealant – per tooth		10	8	8	5	5
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth		10	10	10	10	10
D1353	sealant repair – per tooth		5	5	5	5	5
D1510	space maintainer – fixed, unilateral		35	25	25	25	15
D1516	space maintainer – fixed – bilateral, maxillary		35	25	25	25	15
D1517	space maintainer – fixed – bilateral, mandibular		35	25	25	25	15
D1520	space maintainer – removable – unilateral		45	40	40	35	20
D1526	space maintainer – removable – bilateral, maxillary		45	40	40	35	20
D1527	space maintainer – removable – bilateral, mandibular		45	40	40	35	20
D1550	re-cement or re-bond space maintainer		15	15	15	5	0
D1555	removal of fixed space maintainer		15	15	15	10	10
D1575	distal shoe space maintainer – fixed – unilateral		35	25	25	25	15
<b>III. RESTORATIVE</b>							
*An additional charge for the cost of precious metal will be applied for any procedure using noble, high noble, or titanium metal not to exceed \$150 per unit.							
D2140	amalgam – one surface, primary or permanent		15	8	0	0	0
D2150	amalgam – two surfaces, primary or permanent		20	15	0	0	0
D2160	amalgam – three surfaces, primary or permanent		25	22	0	0	0
D2161	amalgam – four or more surfaces, primary or permanent		30	28	0	0	0
D2330	resin-based composite – one surface, anterior		20	10	0	0	0
D2331	resin-based composite – two surfaces, anterior		25	20	0	0	0
D2332	resin-based composite – three surfaces, anterior		30	30	0	0	0
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		40	38	0	0	0
D2390	resin-based composite crown, anterior		70	45	40	25	20
D2391	resin-based composite – one surface, posterior		65	50	40	30	25
D2392	resin-based composite – two surfaces, posterior		85	55	45	40	35
D2393	resin-based composite – three surfaces, posterior		105	85	75	55	45
D2394	resin-based composite – four or more surfaces, posterior		120	95	75	55	45
D2510	inlay – metallic – one surface		200	185	175	150	115
D2520	inlay – metallic – two surfaces		200	185	175	150	115
D2530	inlay – metallic – three or more surfaces		200	185	175	150	115
D2542	onlay – metallic – two surfaces		250	225	225	150	115

<sup>1</sup> DBP will pay your office the difference between the Minimum Guarantee listed above and the Member's Copay.

**UNITEDHEALTHCARE DHMO**  
**PRINCIPAL BENEFITS AND COVERAGES - MEMBER COPAYMENTS**  
**EXHIBIT 2 - PART I**



**Dental Benefit  
Providers of California**

Customer Service Phone Number 1-877-732-4337		Plan Name Agreement ID	Laguna 110C	Newport 120C	Malibu 130C	Pismo 140C	Santa Cruz 150C
			DMOCARG00001	DMOCARG00004	DMOCARG00003	DMOCARG00007	DMOCARG00006
			Laguna 110	Newport 120	Malibu 130	Pismo 140	Santa Cruz 150
			DMOCARG00010	DMOCARG00012	DMOCARG00018	DMOCARG00014	DMOCARG00016
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
D2543	onlay – metallic – three surfaces		250	225	225	150	115
D2544	onlay – metallic – four or more surfaces		250	225	225	150	115
D2610	inlay – porcelain/ceramic – one surface		305	250	250	175	125
D2620	inlay – porcelain/ceramic – two surfaces		305	250	250	175	125
D2630	inlay – porcelain/ceramic – three or more surfaces		305	250	250	175	125
D2642	onlay – porcelain/ceramic – two surfaces		305	250	250	175	125
D2643	onlay – porcelain/ceramic – three surfaces		305	250	250	175	125
D2644	onlay – porcelain/ceramic – four or more surfaces		305	250	250	175	125
D2650	inlay – resin-based composite – one surface		305	250	250	175	125
D2651	inlay – resin-based composite – two surfaces		305	250	250	175	125
D2652	inlay – resin-based composite – three or more surfaces		305	250	250	175	125
D2662	onlay – resin-based composite – two surfaces		305	250	250	175	125
D2663	onlay – resin-based composite – three surfaces		305	250	250	175	125
D2664	onlay – resin-based composite – four or more surfaces		305	250	250	175	125
D2710	crown – resin-based composite (indirect)		180	150	150	125	90
D2712	crown – ¾ resin-based composite (indirect)		180	150	150	125	90
D2720	crown – resin with high noble metal*	250	250	250	250	175	125
D2721	crown – resin with predominantly base metal	250	250	250	250	175	125
D2722	crown – resin with noble metal*	250	250	250	250	175	125
D2740	crown – porcelain/ceramic	250	350	300	300	225	215
D2750	crown – porcelain fused to high noble metal*	250	305	250	250	175	125
D2751	crown – porcelain fused to predominantly base metal	250	305	250	250	175	125
D2752	crown – porcelain fused to noble metal*	250	305	250	250	175	125
D2780	crown – ¾ cast high noble metal*		305	250	250	175	125
D2781	crown – ¾ cast predominantly base metal		305	250	250	175	125
D2782	crown – ¾ cast noble metal*		305	250	250	175	125
D2783	crown – ¾ porcelain/ceramic		305	250	250	175	125
D2790	crown – full cast high noble metal*	250	305	250	250	175	125
D2791	crown – full cast predominantly base metal	250	305	250	250	175	125
D2792	crown – full cast noble metal*	250	305	250	250	175	125
D2794	crown – titanium*	250	305	250	250	175	125
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		10	0	0	0	0
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		10	0	0	0	0
D2920	re-cement or re-bond crown		10	0	0	0	0
D2921	reattachment of tooth fragment, incisal edge or cusp		65	65	65	65	65
D2929	prefabricated porcelain/ceramic crown – primary tooth		80	80	80	80	80
D2930	prefabricated stainless steel crown – primary tooth		60	25	25	25	10
D2931	prefabricated stainless steel crown – permanent tooth		60	25	25	25	10

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			Laguna 110	Newport 120	Malibu 130	Pismo 140	Santa Cruz 150
			DMOCARG00010	DMOCARG00012	DMOCARG00018	DMOCARG00014	DMOCARG00016
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
D2932	prefabricated resin crown		45	40	40	35	10
D2933	prefabricated stainless steel crown with resin window		60	40	40	35	20
D2934	prefabricated esthetic coated stainless steel crown – primary tooth		60	60	60	60	60
D2941	interim therapeutic restoration – primary dentition		5	5	5	5	5
D2950	core buildup, including any pins when required		70	50	50	25	10
D2951	pin retention – per tooth, in addition to restoration		15	10	10	10	8
D2952	post and core in addition to crown, indirectly fabricated*		50	50	40	35	20
D2953	each additional indirectly fabricated post – same tooth*		50	50	40	25	10
D2954	prefabricated post and core in addition to crown		30	30	25	20	10
D2955	post removal		10	10	10	10	10
D2957	each additional prefabricated post – same tooth		30	30	30	30	15
D2960	labial veneer (resin laminate) – chairside		270	270	270	270	270
D2961	labial veneer (resin laminate) – laboratory		465	465	465	465	465
D2962	labial veneer (porcelain laminate) – laboratory		560	560	560	560	560
D2971	additional procedures to construct new crown under existing partial denture framework		50	50	50	35	25
D2975	coping		80	80	80	80	80
D2980	crown repair necessitated by restorative material failure		45	45	45	45	45
D2990	resin infiltration of incipient smooth surface lesions		5	5	5	5	5
<b>IV. ENDODONTICS</b>							
D3110	pulp cap – direct (excluding final restoration)		5	5	0	0	0
D3120	pulp cap – indirect (excluding final restoration)		5	5	0	0	0
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament		25	5	0	0	0
D3221	pulpal debridement, primary and permanent teeth		55	30	30	15	5
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development		60	60	60	60	60
D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		40	40	40	25	5
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)		40	40	40	25	5
D3310	endodontic therapy, anterior tooth (excluding final restoration)		125	125	95	75	45
D3320	endodontic therapy, premolar tooth (excluding final restoration)		215	175	175	150	75
D3330	endodontic therapy, molar tooth (excluding final restorations)	450	365	325	305	275	115
D3331	treatment of root canal obstruction; non-surgical access		115	85	85	85	65
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		115	85	85	65	45
D3333	internal root repair of perforation defects		115	85	85	65	45
D3346	retreatment of previous root canal therapy – anterior		155	145	115	100	70

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CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
D3347	retreatment of previous root canal therapy – premolar		245	195	175	170	100
D3348	retreatment of previous root canal therapy – molar		415	345	300	295	140
D3351	apexification/recalcification – initial visit (apical closure/calific repair of perforations, root resorption, etc.)		70	70	70	65	50
D3352	apexification/recalcification – interim medication replacement		70	70	70	65	45
D3353	apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calific repair of perforations, root resorption, etc.)		70	70	70	65	45
D3355	Pulpal regeneration - initial visit		65	65	65	65	65
D3356	Pulpal regeneration -interim medicament replacement		65	65	65	65	65
D3357	Pulpal regeneration - completion of treatment		65	65	65	65	65
D3410	apicoectomy – anterior		115	95	95	95	75
D3421	apicoectomy – premolar (first root)		125	95	95	95	75
D3425	apicoectomy – molar (first root)		140	95	95	95	75
D3426	apicoectomy – (each additional root)		95	55	55	55	35
D3427	periradicular surgery without apicoectomy		250	250	250	250	250
D3430	retrograde filling – per root		60	55	55	55	35
D3450	root amputation – per root		110	95	95	95	75
D3460	endodontic endosseous implant		970	970	970	970	970
D3910	surgical procedure for isolation of tooth with rubber dam		25	15	15	15	15
D3920	hemisection (including any root removal), not including root canal therapy		90	90	90	90	75
D3950	canal preparation and fitting of preformed dowel or post		15	15	15	15	15
<b>V. PERIODONTICS</b>							
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant		150	130	115	115	50
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant		95	85	80	75	35
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth		15	15	15	15	15
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant		160	150	150	140	115
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant		115	110	95	85	85
D4245	apically positioned flap		175	165	165	165	155
D4249	clinical crown lengthening – hard tissue		175	150	145	115	115
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant		385	355	325	325	225
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant		300	275	225	215	155
D4263	bone replacement graft – retained natural tooth – first site in quadrant		235	205	175	175	175

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CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant		90	90	90	75	75
D4270	pedicle soft tissue graft procedure		255	235	225	215	195
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)		100	90	85	65	50
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft		235	235	235	235	235
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		275	275	275	275	275
D4320	provisional splinting – intracoronal		75	75	75	75	75
D4321	provisional splinting – extracoronal		75	75	75	75	75
D4341	periodontal scaling and root planing – four or more teeth per quadrant		55	55	45	40	25
D4342	periodontal scaling and root planing – one to three teeth per quadrant		55	50	45	28	15
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		32	32	24	24	12
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit		55	55	50	40	25
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth		65	65	55	35	55
D4910	periodontal maintenance		40	40	30	30	15
D4920	unscheduled dressing change (by someone other than treating dentist or their		0	0	0	0	0
D4921	gingival irrigation - per quadrant		0	0	0	0	0

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CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
<b>VI. PROSTHODONTICS, REMOVABLE</b>							
<b>* Laboratory Upgrades including specialized services for Dentures are not covered. Member are responsible for the laboratory fee charged to the dentist by the dental laboratory.</b>							
D5110	complete denture – maxillary	350	425	350	275	225	150
D5120	complete denture – mandibular	350	425	350	275	225	150
D5130	immediate denture – maxillary	350	440	400	315	250	150
D5140	immediate denture – mandibular	350	440	400	315	250	150
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	350	400	325	250	275	115
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	350	400	325	250	275	115
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	350	450	425	325	275	165
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	350	450	425	325	275	165
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	350	160	145	115	55	45
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	350	170	155	115	55	45
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	350	160	145	115	55	45
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	350	170	155	115	55	45
D5225	maxillary partial denture – flexible base (including any clasps, rests and teeth)	350	450	425	325	350	325
D5226	mandibular partial denture – flexible base (including any clasps, rests and teeth)	350	450	425	325	350	325
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	350	330	300	275	260	150
D5283	removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	350	330	300	275	260	150
D5410	adjust complete denture – maxillary		15	10	10	0	0
D5411	adjust complete denture – mandibular		15	10	10	0	0
D5421	adjust partial denture – maxillary		15	10	10	0	0
D5422	adjust partial denture – mandibular		15	10	10	0	0
D5511	repair broken complete denture base, mandibular		40	35	30	25	15
D5512	repair broken complete denture base, maxillary		40	35	30	25	15
D5520	replace missing or broken teeth – complete denture (each tooth)		40	35	30	25	15
D5611	repair resin partial denture base, mandibular		40	35	30	25	15
D5612	repair resin partial denture base, maxillary		40	35	30	25	15
D5621	repair cast partial framework, mandibular		40	35	30	25	15

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CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
D5622	repair cast partial framework, maxillary		40	35	30	25	15
D5630	repair or replace broken clasp – per tooth		40	35	30	25	15
D5640	replace broken teeth – per tooth		40	35	30	25	15
D5650	add tooth to existing partial denture		40	40	30	25	15
D5660	add clasp to existing partial denture – per tooth		50	40	30	25	15
D5670	replace all teeth and acrylic on cast metal framework (maxillary)		165	150	150	150	125
D5671	replace all teeth and acrylic on cast metal framework (mandibular)		165	150	150	150	125
D5710	rebase complete maxillary denture		105	75	65	55	45
D5711	rebase complete mandibular denture		105	75	65	55	45
D5720	rebase maxillary partial denture		105	75	65	55	45
D5721	rebase mandibular partial denture		105	75	65	55	45
D5730	reline complete maxillary denture (chairside)		90	55	55	35	0
D5731	reline complete mandibular denture (chairside)		90	55	55	35	0
D5740	reline maxillary partial denture (chairside)		90	55	55	35	0
D5741	reline mandibular partial denture (chairside)		90	55	55	35	0
D5750	reline complete maxillary denture (laboratory)		115	75	75	55	40
D5751	reline complete mandibular denture (laboratory)		115	75	75	55	40
D5760	reline maxillary partial denture (laboratory)		115	75	75	55	40
D5761	reline mandibular partial denture (laboratory)		115	75	75	55	40
D5820	interim partial denture (maxillary)		160	145	115	55	45
D5821	interim partial denture (mandibular)		170	155	115	55	45
D5850	tissue conditioning, maxillary		35	20	20	10	10
D5851	tissue conditioning, mandibular		35	20	20	10	10
D5863	overdenture - complete maxillary		425	425	425	425	425
D5864	overdenture - complete mandibular		450	450	450	450	450
D5865	overdenture - partial maxillary		425	425	425	425	425
D5866	overdenture - partial mandibular		450	450	450	450	450
D5876	add metal substructure to acrylic full denture (per arch)		105	75	65	55	45
<b>VIII. IMPLANT SERVICES</b>							
D6010	surgical placement of implant body: endosteal implant		1,035	1,035	1,035	1,035	1,035
D6013	surgical placement of a mini-implant		1,185	1,185	1,185	1,185	1,185
D6052	semi-precision attachment abutment		525	525	525	525	525
D6055	connecting bar – implant supported or abutment supported		390	390	390	390	390
D6056	prefabricated abutment – includes modification and placement		290	290	290	290	290
D6057	custom fabricated abutment – includes placement		395	395	395	395	395
D6058	abutment supported porcelain/ceramic crown		710	710	710	710	710
D6059	abutment supported porcelain fused to metal crown (high noble metal)		710	710	710	710	710
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)		575	575	575	575	575

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CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
D6061	abutment supported porcelain fused to metal crown (noble metal)		635	635	635	635	635
D6062	abutment supported cast metal crown (high noble metal)		675	675	675	675	675
D6063	abutment supported cast metal crown (predominantly base metal)		595	595	595	595	595
D6064	abutment supported cast metal crown (noble metal)		620	620	620	620	620
D6065	implant supported porcelain/ceramic crown		740	740	740	740	740
D6066	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)		720	720	720	720	720
D6067	implant supported metal crown (titanium, titanium alloy, high noble metal)		730	730	730	730	730
D6068	abutment supported retainer for porcelain/ceramic FPD		680	680	680	680	680
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)		705	705	705	705	705
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)		630	630	630	630	630
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)		680	680	680	680	680
D6072	abutment supported retainer for cast metal FPD (high noble metal)		690	690	690	690	690
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)		630	630	630	630	630
D6074	abutment supported retainer for cast metal FPD (noble metal)		670	670	670	670	670
D6075	implant supported retainer for ceramic FPD		740	740	740	740	740
D6076	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)		705	705	705	705	705
D6077	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)		665	665	665	665	665
D6080	implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments		80	80	80	80	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		191	191	191	191	191
D6090	repair implant supported prosthesis, by report		130	130	130	130	130
D6091	replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment		200	200	200	200	200
D6092	re-cement or re-bond implant/abutment supported crown		60	60	60	60	60
D6093	re-cement or re-bond implant/abutment supported fixed partial denture		80	80	80	80	80
D6094	abutment supported crown (titanium)		560	560	560	560	560
D6095	repair implant abutment, by report		150	150	150	150	150
D6096	remove broken implant retaining screw		10	10	10	10	10
D6100	implant removal, by report		250	250	250	250	250
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		255	255	255	255	255

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CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
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		315	315	315	315	315
D6103	bone graft for repair of peri-implant defect – does not include flap entry and closure		265	265	265	265	265
D6110	implant /abutment supported removable denture for edentulous arch – maxillary		925	925	925	925	925
D6111	implant /abutment supported removable denture for edentulous arch –		925	925	925	925	925
D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary		925	925	925	925	925
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular		925	925	925	925	925
D6190	radiographic/surgical implant index, by report		145	145	145	145	145
D6194	abutment supported retainer crown for FPD – (titanium)		575	575	575	575	575
<b>IX. PROSTHODONTICS, FIXED</b>							
*An additional charge for the cost of precious metal will be applied for any procedure using noble, high noble, or titanium metal not to exceed \$150 per unit.							
D6205	pontic – indirect resin based composite		250	250	250	250	250
D6210	pontic – cast high noble metal*	250	305	250	250	175	125
D6211	pontic – cast predominantly base metal	250	305	250	250	175	125
D6212	pontic – cast noble metal*	250	305	250	250	175	125
D6214	pontic – titanium*	250	305	250	250	175	125
D6240	pontic – porcelain fused to high noble metal*	250	305	250	250	175	125
D6241	pontic – porcelain fused to predominantly base metal	250	305	250	250	175	125
D6242	pontic – porcelain fused to noble metal*	250	305	250	250	175	125
D6245	pontic – porcelain/ceramic	250	350	300	300	225	215
D6250	pontic – resin with high noble metal*	250	250	250	250	175	125
D6251	pontic – resin with predominantly base metal	250	250	250	250	175	125
D6252	pontic – resin with noble metal*	250	250	250	250	175	125
D6253	provisional pontic – further treatment or completion of diagnosis necessary prior to final impression		175	175	175	175	175
D6545	retainer – cast metal for resin bonded fixed prosthesis		250	250	250	250	250
D6548	retainer – porcelain/ceramic for resin bonded fixed prosthesis		300	300	300	300	300
D6549	resin retainer – for resin bonded fixed prosthesis		85	85	85	85	85
D6600	retainer inlay – porcelain/ceramic, two surfaces		325	270	270	195	145
D6601	retainer inlay – porcelain/ceramic, three or more surfaces		325	270	270	195	145
D6602	retainer inlay – cast high noble metal, two surfaces*		200	185	175	150	115
D6603	retainer inlay – cast high noble metal, three or more surfaces*		200	185	175	150	115
D6604	retainer inlay – cast predominantly base metal, two surfaces		200	185	175	150	115
D6605	retainer inlay – cast predominantly base metal, three or more surfaces		200	185	175	150	115

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**EXHIBIT 2 - PART I**



**Dental Benefit  
Providers of California**

Customer Service Phone Number 1-877-732-4337		Plan Name Agreement ID	Laguna 110C	Newport 120C	Malibu 130C	Pismo 140C	Santa Cruz 150C
			DMOCARG00001	DMOCARG00004	DMOCARG00003	DMOCARG00007	DMOCARG00006
			Laguna 110	Newport 120	Malibu 130	Pismo 140	Santa Cruz 150
			DMOCARG00010	DMOCARG00012	DMOCARG00018	DMOCARG00014	DMOCARG00016
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
D6606	retainer inlay – cast noble metal, two surfaces*		200	185	175	150	115
D6607	retainer inlay – cast noble metal, three or more surfaces*		200	185	175	150	115
D6608	retainer onlay – porcelain/ceramic, two surfaces		335	280	280	205	155
D6609	retainer onlay – porcelain/ceramic, three or more surfaces		335	280	280	205	155
D6610	retainer onlay – cast high noble metal, two surfaces*		200	185	175	150	115
D6611	retainer onlay – cast high noble metal, three or more surfaces*		200	175	175	150	115
D6612	retainer onlay – cast predominantly base metal, two surfaces		200	175	175	155	150
D6613	retainer onlay – cast predominantly base metal, three or more surfaces		200	175	175	155	150
D6614	retainer onlay – cast noble metal, two surfaces*		200	175	175	150	115
D6615	retainer onlay – cast noble metal, three or more surfaces*		200	175	175	155	115
D6624	retainer inlay – titanium*		305	250	250	175	125
D6634	retainer onlay – titanium*		305	250	250	175	125
D6710	retainer crown – indirect resin based composite		185	185	185	185	185
D6720	retainer crown – resin with high noble metal*	250	250	250	250	175	125
D6721	retainer crown – resin with predominantly base metal	250	250	250	250	175	125
D6722	retainer crown – resin with noble metal*	250	250	250	250	175	125
D6740	retainer crown – porcelain/ceramic	250	350	300	300	225	215
D6750	retainer crown – porcelain fused to high noble metal*	250	305	250	250	175	125
D6751	retainer crown – porcelain fused to predominantly base metal	250	305	250	250	175	125
D6752	retainer crown – porcelain fused to noble metal*	250	305	250	250	175	125
D6780	retainer crown – ¾ cast high noble metal*		305	250	250	175	125
D6781	retainer crown – ¾ cast predominantly base metal		305	250	250	175	125
D6782	retainer crown – ¾ cast noble metal*		305	250	250	175	125
D6783	retainer crown – ¾ porcelain/ceramic		305	300	300	175	175
D6790	retainer crown – full cast high noble metal*	250	305	250	250	175	125
D6791	retainer crown – full cast predominantly base metal	250	305	250	250	175	125
D6792	retainer crown – full cast noble metal*	250	305	250	250	175	125
D6794	retainer crown – titanium*	250	305	250	250	175	125
D6920	connector bar		85	85	85	85	85
D6930	re-cement or re-bond fixed partial denture		10	0	0	0	0
D6940	stress breaker		150	125	125	115	110
D6980	fixed partial denture repair necessitated by restorative material failure		140	140	140	140	140
<b>X. ORAL &amp; MAXILLOFACIAL SURGERY</b>							
D7111	extraction, coronal remnants – primary tooth		10	10	8	0	0
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)		15	10	8	0	0
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		50	30	30	25	15
D7220	removal of impacted tooth – soft tissue		65	65	55	50	25

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**Dental Benefit  
Providers of California**

Customer Service Phone Number 1-877-732-4337		Plan Name Agreement ID	Laguna 110C	Newport 120C	Malibu 130C	Pismo 140C	Santa Cruz 150C
			DMOCARG00001	DMOCARG00004	DMOCARG00003	DMOCARG00007	DMOCARG00006
			Laguna 110	Newport 120	Malibu 130	Pismo 140	Santa Cruz 150
			DMOCARG00010	DMOCARG00012	DMOCARG00018	DMOCARG00014	DMOCARG00016
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
D7230	removal of impacted tooth – partially bony		95	85	85	75	50
D7240	removal of impacted tooth – completely bony		135	125	125	115	75
D7241	removal of impacted tooth – completely bony, with unusual surgical complications		155	150	150	135	90
D7250	removal of residual tooth roots (cutting procedure)		40	40	40	40	0
D7251	coronectomy – intentional partial tooth removal		150	150	150	150	150
D7261	primary closure of a sinus perforation		225	225	225	225	225
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced		80	50	50	50	50
D7280	exposure of an unerupted tooth		120	85	85	85	85
D7282	mobilization of erupted or malpositioned tooth to aid eruption		120	90	90	90	85
D7285	incisional biopsy of oral tissue – hard (bone, tooth)		150	150	150	0	0
D7286	incisional biopsy of oral tissue – soft		60	60	60	0	0
D7287	exfoliative cytological sample collection		20	20	20	20	20
D7288	brush biopsy – transepithelial sample collection		20	20	20	20	20
D7290	surgical repositioning of teeth		75	75	75	75	75
D7296	corticotomy - one to three teeth or tooth spaces, per quadrant		75	75	75	75	75
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant		75	75	75	75	75
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		60	40	40	25	0
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		45	15	15	10	0
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		80	60	60	40	0
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		60	25	25	20	0
D7340	vestibuloplasty – ridge extension (secondary epithelialization)		215	215	215	215	215
D7350	vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)		670	670	670	670	670
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm		70	70	70	70	70
D7451	removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm		110	110	110	110	110
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm		100	100	100	100	100
D7461	removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm		125	125	125	125	125
D7471	removal of lateral exostosis (maxilla or mandible)		100	85	85	75	75
D7472	removal of torus palatinus		100	65	65	50	25
D7473	removal of torus mandibularis		100	65	65	50	25
D7485	reduction of osseous tuberosity		100	65	65	50	25

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**Dental Benefit  
Providers of California**

Customer Service Phone Number 1-877-732-4337		Plan Name Agreement ID	Laguna 110C	Newport 120C	Malibu 130C	Pismo 140C	Santa Cruz 150C
			DMOCARG00001	DMOCARG00004	DMOCARG00003	DMOCARG00007	DMOCARG00006
			Laguna 110	Newport 120	Malibu 130	Pismo 140	Santa Cruz 150
			DMOCARG00010	DMOCARG00012	DMOCARG00018	DMOCARG00014	DMOCARG00016
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
D7510	incision and drainage of abscess – intraoral soft tissue		40	35	35	25	15
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		60	35	35	25	15
D7520	incision and drainage of abscess – extraoral soft tissue		70	70	70	70	70
D7521	incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		190	190	190	190	190
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue		40	40	40	40	40
D7881	occlusal orthotic device adjustment		15	10	10	0	0
D7910	suture of recent small wounds up to 5 cm		25	25	25	25	15
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure		90	45	45	25	0
D7963	frenuloplasty		90	45	45	25	0
D7970	excision of hyperplastic tissue – per arch		55	55	55	35	25
D7971	excision of pericoronal gingiva		40	40	40	30	20
D7972	surgical reduction of fibrous tuberosity		100	100	100	100	40
<b>XII. ADJUNCTIVE GENERAL SERVICES</b>							
D9110	palliative (emergency) treatment of dental pain – minor procedure		10	10	10	10	5
D9211	regional block anesthesia		0	0	0	0	0
D9212	trigeminal division block anesthesia		0	0	0	0	0
D9215	local anesthesia in conjunction with operative or surgical procedures		0	0	0	0	0
D9219	evaluation for deep sedation or general anesthesia		0	0	0	0	0
D9222	deep sedation/general anesthesia – first 15 minutes		150	150	150	150	150
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment		75	75	75	75	75
D9230	inhalation of nitrous oxide/anxiolysis, analgesia		30	30	30	30	30
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes		140	140	140	140	140
D9243	intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment		70	70	70	70	70
D9248	non-intravenous conscious sedation		50	50	50	50	50
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		25	0	0	0	0
D9311	consultation with a medical health care professional		5	5	5	5	5
D9430	office visit for observation (during regularly scheduled hours) – no other services performed		5	5	5	5	5
D9440	office visit – after regularly scheduled hours		35	35	35	35	35
D9450	case presentation, detailed and extensive treatment planning		0	0	0	0	0
D9930	treatment of complications (post-surgical) – unusual circumstances, by report		0	0	0	0	0
D9943	occlusal guard adjustment		15	10	10	0	0
D9944	occlusal guard – hard appliance, full arch		120	100	85	85	85

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Customer Service Phone Number 1-877-732-4337		Plan Name Agreement ID	Laguna 110C	Newport 120C	Malibu 130C	Pismo 140C	Santa Cruz 150C
			DMOCARG00001	DMOCARG00004	DMOCARG00003	DMOCARG00007	DMOCARG00006
			Laguna 110	Newport 120	Malibu 130	Pismo 140	Santa Cruz 150
			DMOCARG00010	DMOCARG00012	DMOCARG00018	DMOCARG00014	DMOCARG00016
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT Code	Description	Minimum Guarantee <sup>1</sup>	Member Copayment				
D9945	occlusal guard – soft appliance, full arch		120	100	85	85	85
D9946	occlusal guard – hard appliance, partial arch		60	50	43	43	43
D9951	occlusal adjustment – limited		35	35	30	30	0
D9952	occlusal adjustment – complete		100	90	90	80	0
D9971	odontoplasty 1-2 teeth; includes removal of enamel projections		20	20	20	20	20
D9972	external bleaching – per arch – performed in office		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
D9995	teledentistry – synchronous; real-time encounter		0	0	0	0	0
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review		0	0	0	0	0
	Broken Appointment, with no prior notification at least 24 hrs before the scheduled appointment		20	20	20	10	10

**Footnotes:** Specialty family calendar year maximum does not apply to the listed plans. All copays listed are applicable in the specialist office with the exception of services provided by a Pedodontist. Listed Copayments do not apply to Covered Service provided by a Pedodontist. Instead, the parent or guardian is responsible for 49% of the pedodontist's contracted rate.

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

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**UNITEDHEALTHCARE / LINCOLN FINANCIAL GROUP DHMO**  
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**EXHIBIT 2 - PART II**



Customer Service Phone Number 1-888-877-7828		Plan Name Agreement ID	Plan 450C	Plan 550C	Plan 650C	Plan 750C
			DMOCARG00005	DMOCARG00008	DMOCARG00009	DMOCARG00002
			Plan 450	Plan 550	Plan 650	Plan 750
			DMOCARG00011	DMOCARG00013	DMOCARG00015	DMOCARG00017
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
<b>I. DIAGNOSTIC</b>						
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	0	0	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	0	0
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)		0	0	0	0
D0171	re-evaluation – post-operative office visit		0	0	5	5
D0180	comprehensive periodontal evaluation – new or established patient		0	0	0	0
D0190	screening of a patient		0	0	5	5
D0191	assessment of a patient		0	0	5	5
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
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector		0	0	0	0
D0251	extra-oral posterior dental 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	0	0	0
D0274	bitewings – four radiographic images		0	0	0	0
D0277	vertical bitewings – 7 to 8 radiographic images		0	0	0	0
D0330	panoramic radiographic image		5	0	0	0
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis		50	50	50	50
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report		10	0	0	0
D0411	HbA1c in-office point of service testing		10	10	10	10
D0412	blood glucose level test – in-office using a glucose meter		3	3	10	10
D0414	laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report		0	0	0	0
D0415	collection of microorganisms for culture and sensitivity		0	0	0	0
D0416	viral culture		10	10	10	10
D0417	collection and preparation of saliva sample for laboratory diagnostic testing		10	10	10	10
D0418	analysis of saliva sample		10	10	10	10
D0422	collection and preparation of genetic sample material for laboratory analysis and report		0	0	0	0
D0423	genetic test for susceptibility to diseases – specimen analysis		0	0	0	0
D0425	caries susceptibility tests		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	40	20	20	20	20
D0460	pulp vitality tests		0	0	0	0

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Customer Service Phone Number 1-888-877-7828		Plan Name Agreement ID	Plan 450C	Plan 550C	Plan 650C	Plan 750C
			DMOCARG00005	DMOCARG00008	DMOCARG00009	DMOCARG00002
			Plan 450	Plan 550	Plan 650	Plan 750
			DMOCARG00011	DMOCARG00013	DMOCARG00015	DMOCARG00017
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
D0470	diagnostic casts		12	0	0	0
D0472	accession of tissue, gross examination, preparation and transmission of written report		0	0	0	0
D0473	accession of tissue, gross and microscopic examination, preparation and transmission of written report		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
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 *Member is responsible for \$5.00 office visit fee for Plan Name ending in "C" (e.g. 450C).	5	0/5*	0/5*	0/5*	0/5*
<b>II. PREVENTIVE</b>						
* Additional Prophy within 6 months will be based upon the necessity recommended by the provider.						
D1110	prophylaxis – adult		0	0	0	0
-----	Prophylaxis - adult: Additional Prophy within 6 months*		25	25	25	25
D1120	prophylaxis – child		0	0	0	0
-----	Prophylaxis - child: Additional Prophy within 6 months*		25	25	25	25
D1206	topical application of fluoride varnish		0	0	0	0
D1208	topical application of fluoride – excluding varnish		0	0	0	0
D1310	nutritional counseling for control of dental disease		0	0	0	0
D1320	tobacco counseling for the control and prevention of oral disease		0	0	0	0
D1330	oral hygiene instructions		0	0	0	0
D1351	sealant – per tooth		8	5	5	0
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth		8	5	5	0
D1353	sealant repair – per tooth		4	3	3	0
D1510	space maintainer – fixed, unilateral		32	25	20	0
D1516	space maintainer – fixed – bilateral, maxillary		32	25	20	0
D1517	space maintainer – fixed – bilateral, mandibular		32	25	20	0
D1520	space maintainer – removable – unilateral		50	45	30	0
D1526	space maintainer – removable – bilateral, maxillary		50	45	30	0
D1527	space maintainer – removable – bilateral, mandibular		50	45	30	0
D1550	re-cement or re-bond space maintainer		12	10	5	0
D1555	removal of fixed space maintainer		12	10	10	0
D1575	distal shoe space maintainer – fixed – unilateral		32	25	20	0

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Customer Service Phone Number 1-888-877-7828		Plan Name Agreement ID	Plan 450C	Plan 550C	Plan 650C	Plan 750C
			DMOCARG00005	DMOCARG00008	DMOCARG00009	DMOCARG00002
			Plan 450	Plan 550	Plan 650	Plan 750
			DMOCARG00011	DMOCARG00013	DMOCARG00015	DMOCARG00017
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
<b>III. RESTORATIVE</b>						
*An additional charge for the cost of precious metal will be applied for any procedure using noble, high noble, or titanium metal not to exceed \$150 per unit.						
D2140	amalgam – one surface, primary or permanent		10	0	0	0
D2150	amalgam – two surfaces, primary or permanent		14	0	0	0
D2160	amalgam – three surfaces, primary or permanent		18	0	0	0
D2161	amalgam – four or more surfaces, primary or permanent		25	0	0	0
D2330	resin-based composite – one surface, anterior		14	0	0	0
D2331	resin-based composite – two surfaces, anterior		18	0	0	0
D2332	resin-based composite – three surfaces, anterior		25	0	0	0
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		35	0	0	0
D2390	resin-based composite crown, anterior		75	40	25	20
D2391	resin-based composite – one surface, posterior		40	40	35	25
D2392	resin-based composite – two surfaces, posterior		50	50	45	30
D2393	resin-based composite – three surfaces, posterior		70	70	55	35
D2394	resin-based composite – four or more surfaces, posterior		90	90	65	40
D2510	inlay – metallic – one surface		185	160	135	100
D2520	inlay – metallic – two surfaces		185	160	135	100
D2530	inlay – metallic – three or more surfaces		185	160	135	100
D2542	onlay – metallic – two surfaces		225	215	135	100
D2543	onlay – metallic – three surfaces		225	215	135	100
D2544	onlay – metallic – four or more surfaces		225	215	135	100
D2610	inlay – porcelain/ceramic – one surface		280	225	150	100
D2620	inlay – porcelain/ceramic – two surfaces		280	225	150	100
D2630	inlay – porcelain/ceramic – three or more surfaces		280	225	150	100
D2642	onlay – porcelain/ceramic – two surfaces		280	225	150	100
D2643	onlay – porcelain/ceramic – three surfaces		280	225	150	100
D2644	onlay – porcelain/ceramic – four or more surfaces		280	225	150	100
D2650	inlay – resin-based composite – one surface		280	225	150	100
D2651	inlay – resin-based composite – two surfaces		280	225	150	100
D2652	inlay – resin-based composite – three or more surfaces		280	225	150	100
D2662	onlay – resin-based composite – two surfaces		280	225	150	100
D2663	onlay – resin-based composite – three surfaces		280	225	150	100
D2664	onlay – resin-based composite – four or more surfaces		280	225	150	100
D2710	crown – resin-based composite (indirect)		150	135	115	100
D2712	crown – ¾ resin-based composite (indirect)		150	135	115	100
D2720	crown – resin with high noble metal*	250	225	225	150	100
D2721	crown – resin with predominantly base metal	250	225	225	150	100
D2722	crown – resin with noble metal*	250	225	225	150	100
D2740	crown – porcelain/ceramic	250	325	285	210	215

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Customer Service Phone Number 1-888-877-7828		Plan Name Agreement ID	Plan 450C	Plan 550C	Plan 650C	Plan 750C
			DMOCARG00005	DMOCARG00008	DMOCARG00009	DMOCARG00002
			Plan 450	Plan 550	Plan 650	Plan 750
			DMOCARG00011	DMOCARG00013	DMOCARG00015	DMOCARG00017
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
D2750	crown – porcelain fused to high noble metal*	250	280	225	150	100
D2751	crown – porcelain fused to predominantly base metal	250	280	225	150	100
D2752	crown – porcelain fused to noble metal*	250	280	225	150	100
D2780	crown – ¾ cast high noble metal*		280	225	150	100
D2781	crown – ¾ cast predominantly base metal		280	225	150	100
D2782	crown – ¾ cast noble metal*		280	225	150	100
D2783	crown – ¾ porcelain/ceramic		280	225	150	100
D2790	crown – full cast high noble metal*	250	280	225	150	100
D2791	crown – full cast predominantly base metal	250	280	225	150	100
D2792	crown – full cast noble metal*	250	280	225	150	100
D2794	crown – titanium*	250	280	225	150	100
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		10	0	0	0
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		10	0	0	0
D2920	re-cement or re-bond crown		10	0	0	0
D2921	reattachment of tooth fragment, incisal edge or cusp		7	0	0	0
D2929	prefabricated porcelain/ceramic crown – primary tooth		40	35	25	0
D2930	prefabricated stainless steel crown – primary tooth		50	40	30	0
D2931	prefabricated stainless steel crown – permanent tooth		60	40	30	0
D2932	prefabricated resin crown		40	35	25	0
D2933	prefabricated stainless steel crown with resin window		60	40	30	0
D2934	prefabricated esthetic coated stainless steel crown – primary tooth		60	60	60	60
D2940	protective restoration		8	0	0	0
D2941	interim therapeutic restoration – primary dentition		6	0	0	0
D2949	restorative foundation for an indirect restoration		14	0	0	0
D2950	core buildup, including any pins when required		80	40	15	10
D2951	pin retention – per tooth, in addition to restoration		10	0	8	5
D2952	post and core in addition to crown, indirectly fabricated*		80	70	30	20
D2953	each additional indirectly fabricated post – same tooth*		80	70	15	20
D2954	prefabricated post and core in addition to crown		45	25	10	10
D2955	post removal		10	10	10	10
D2957	each additional prefabricated post – same tooth		30	25	25	15
D2960	labial veneer (resin laminate) – chairside		270	270	270	270
D2961	labial veneer (resin laminate) – laboratory		465	465	465	465
D2962	labial veneer (porcelain laminate) – laboratory		560	560	560	560
D2971	additional procedures to construct new crown under existing partial denture framework		50	50	35	25
D2975	coping		80	80	80	80
D2980	crown repair necessitated by restorative material failure		45	45	45	45
D2990	resin infiltration of incipient smooth surface lesions		8	5	5	0

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CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
<b>IV. ENDODONTICS</b>						
D3110	pulp cap – direct (excluding final restoration)		0	0	0	0
D3120	pulp cap – indirect (excluding final restoration)		0	0	0	0
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament		0	0	0	0
D3221	pulpal debridement, primary and permanent teeth		20	20	10	0
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development		60	60	60	60
D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		60	35	15	0
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)		60	35	15	0
D3310	endodontic therapy, anterior tooth (excluding final restoration)		115	85	55	40
D3320	endodontic therapy, premolar tooth (excluding final restoration)		180	135	115	70
D3330	endodontic therapy, molar tooth (excluding final restoration)	450	285	250	225	100
D3331	treatment of root canal obstruction; non-surgical access		85	85	65	55
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		85	85	65	45
D3333	internal root repair of perforation defects		85	85	65	55
D3346	retreatment of previous root canal therapy – anterior		135	105	80	65
D3347	retreatment of previous root canal therapy – premolar		200	155	140	90
D3348	retreatment of previous root canal therapy – molar		315	270	250	125
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)		80	70	55	50
D3352	apexification/recalcification – interim medication replacement		55	50	55	45
D3353	apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)		60	60	55	45
D3355	Pulpal regeneration - initial visit		80	70	55	50
D3356	Pulpal regeneration -interim medicament replacement		55	50	55	45
D3357	Pulpal regeneration - completion of treatment		60	60	55	45
D3410	apicoectomy – anterior		125	105	75	65
D3421	apicoectomy – premolar (first root)		145	105	75	65
D3425	apicoectomy – molar (first root)		150	105	75	65
D3426	apicoectomy – (each additional root)		85	45	45	25
D3427	periradicular surgery without apicoectomy		85	45	45	25
D3428	bone graft in conjunction with periradicular surgery - per tooth, single site		215	155	165	165
D3429	bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site		115	105	90	65
D3430	retrograde filling – per root		55	50	45	25
D3450	root amputation – per root		80	105	75	65
D3460	endodontic endosseous implant		970	970	970	970
D3910	surgical procedure for isolation of tooth with rubber dam		25	15	10	10
D3920	hemisection (including any root removal), not including root canal therapy		75	85	70	70
D3950	canal preparation and fitting of preformed dowel or post		15	12	10	10

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			Plan 450	Plan 550	Plan 650	Plan 750
			DMOCARG00011	DMOCARG00013	DMOCARG00015	DMOCARG00017
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
<b>V. PERIODONTICS</b>						
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant		140	100	90	40
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant		70	65	65	20
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth		23	21	21	7
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant		180	155	125	100
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant		90	105	75	65
D4245	apically positioned flap		180	155	140	145
D4249	clinical crown lengthening – hard tissue		195	175	95	95
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant		350	275	275	200
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant		225	165	275	135
D4263	bone replacement graft – retained natural tooth – first site in quadrant		215	155	165	165
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant		115	105	90	65
D4270	pedicle soft tissue graft procedure		215	190	175	175
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)		90	85	45	25
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft		215	205	202	175
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		108	103	101	88
D4320	provisional splinting – intracoronal		75	75	75	75
D4321	provisional splinting – extracoronal		75	75	75	75
D4341	periodontal scaling and root planing – four or more teeth per quadrant		50	40	35	20
D4342	periodontal scaling and root planing – one to three teeth per quadrant		50	40	35	10
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		24	32	20	8
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit		50	45	35	20
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth		35	50	55	40
D4910	periodontal maintenance		30	40	25	10
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)		0	0	0	0
D4921	gingival irrigation - per quadrant		0	0	0	0

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CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
<b>VI. PROSTHODONTICS (REMOVABLE)</b>						
* Laboratory Upgrades including specialized services for Dentures are not covered. Member are responsible for the laboratory fee charged to the dentist by the dental laboratory.						
D5110	complete denture – maxillary	350	365	285	215	125
D5120	complete denture – mandibular	350	365	285	215	125
D5130	immediate denture – maxillary	350	385	305	225	125
D5140	immediate denture – mandibular	350	385	305	225	125
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	350	335	295	250	110
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	350	335	295	250	110
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	350	405	315	250	150
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	350	405	315	250	150
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	350	145	115	55	45
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	350	155	115	55	45
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	350	145	115	55	45
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	350	155	115	55	45
D5225	maxillary partial denture – flexible base (including any clasps, rests and teeth)	350	475	315	325	315
D5226	mandibular partial denture – flexible base (including any clasps, rests and teeth)	350	475	315	325	315
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	350	315	275	245	140
D5283	removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	350	315	275	245	140
D5410	adjust complete denture – maxillary		10	5	0	0
D5411	adjust complete denture – mandibular		10	5	0	0
D5421	adjust partial denture – maxillary		10	5	0	0
D5422	adjust partial denture – mandibular		10	5	0	0
D5511	repair broken complete denture base, mandibular		40	35	15	10
D5512	repair broken complete denture base, maxillary		40	35	15	10
D5520	replace missing or broken teeth – complete denture (each tooth)		40	35	15	10
D5611	repair resin partial denture base, mandibular		40	35	15	10
D5612	repair resin partial denture base, maxillary		40	35	15	10
D5621	repair cast partial framework, mandibular		40	35	15	10
D5622	repair cast partial framework, maxillary		40	35	15	10
D5630	repair or replace broken clasp – per tooth		40	35	15	10
D5640	replace broken teeth – per tooth		40	35	15	10
D5650	add tooth to existing partial denture		35	35	15	10
D5660	add clasp to existing partial denture – per tooth		50	35	15	10
D5670	replace all teeth and acrylic on cast metal framework (maxillary)		165	155	125	115
D5671	replace all teeth and acrylic on cast metal framework (mandibular)		165	155	125	115

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CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
D5710	rebase complete maxillary denture		125	85	45	45
D5711	rebase complete mandibular denture		125	85	45	45
D5720	rebase maxillary partial denture		125	85	45	45
D5721	rebase mandibular partial denture		125	85	45	45
D5730	reline complete maxillary denture (chairside)		75	45	25	0
D5731	reline complete mandibular denture (chairside)		75	45	25	0
D5740	reline maxillary partial denture (chairside)		75	45	25	0
D5741	reline mandibular partial denture (chairside)		75	45	25	0
D5750	reline complete maxillary denture (laboratory)		105	65	45	40
D5751	reline complete mandibular denture (laboratory)		105	65	45	40
D5760	reline maxillary partial denture (laboratory)		105	65	45	40
D5761	reline mandibular partial denture (laboratory)		105	65	45	40
D5820	interim partial denture (maxillary)		125	105	45	40
D5821	interim partial denture (mandibular)		125	105	45	40
D5850	tissue conditioning, maxillary		30	10	0	0
D5851	tissue conditioning, mandibular		30	10	0	0
D5863	overdenture - complete maxillary		365	350	350	350
D5864	overdenture - complete mandibular		365	350	350	350
D5865	overdenture - partial maxillary		405	350	350	350
D5866	overdenture - partial mandibular		405	350	350	350
D5876	add metal substructure to acrylic full denture (per arch)		125	85	45	45
D5992	adjust maxillofacial prosthetic appliance, by report		13	6	0	0
<b>VIII. IMPLANT SERVICES</b>						
D6010	surgical placement of implant body: endosteal implant		1,035	1,035	1,035	1,035
D6013	surgical placement of a mini-implant		1,185	1,185	1,185	1,185
D6052	semi-precision attachment abutment		525	525	525	525
D6055	connecting bar – implant supported or abutment supported		390	390	390	390
D6056	prefabricated abutment – includes modification and placement		290	290	290	290
D6057	custom fabricated abutment – includes placement		395	395	395	395
D6058	abutment supported porcelain/ceramic crown		710	710	710	710
D6059	abutment supported porcelain fused to metal crown (high noble metal)		710	710	710	710
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)		575	575	575	575
D6061	abutment supported porcelain fused to metal crown (noble metal)		635	635	635	635
D6062	abutment supported cast metal crown (high noble metal)		675	675	675	675
D6063	abutment supported cast metal crown (predominantly base metal)		595	595	595	595
D6064	abutment supported cast metal crown (noble metal)		620	620	620	620
D6065	implant supported porcelain/ceramic crown		740	740	740	740
D6066	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)		720	720	720	720
D6067	implant supported metal crown (titanium, titanium alloy, high noble metal)		730	730	730	730

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CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
D6068	abutment supported retainer for porcelain/ceramic FPD		680	680	680	680
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)		705	705	705	705
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)		630	630	630	630
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)		680	680	680	680
D6072	abutment supported retainer for cast metal FPD (high noble metal)		690	690	690	690
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)		630	630	630	630
D6074	abutment supported retainer for cast metal FPD (noble metal)		670	670	670	670
D6075	implant supported retainer for ceramic FPD		740	740	740	740
D6076	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)		705	705	705	705
D6077	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)		665	665	665	665
D6080	implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments		80	80	80	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		190	190	190	190
D6085	provisional implant crown		55	55	55	55
D6090	repair implant supported prosthesis, by report		130	130	130	130
D6091	replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment		200	200	200	200
D6092	re-cement or re-bond implant/abutment supported crown		60	60	60	60
D6093	re-cement or re-bond implant/abutment supported fixed partial denture		80	80	80	80
D6094	abutment supported crown (titanium)		560	560	560	560
D6095	repair implant abutment, by report		150	150	150	150
D6096	remove broken implant retaining screw		10	10	10	10
D6100	implant removal, by report		250	250	250	250
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		255	255	255	255
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		315	315	315	315
D6103	bone graft for repair of peri-implant defect – does not include flap entry and closure		265	265	265	265
D6110	implant /abutment supported removable denture for edentulous arch – maxillary		925	925	925	925
D6111	implant /abutment supported removable denture for edentulous arch – mandibular		925	925	925	925
D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary		925	925	925	925
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular		925	925	925	925
D6190	radiographic/surgical implant index, by report		145	145	145	145
D6194	abutment supported retainer crown for FPD – (titanium)		575	575	575	575

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CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
<b>IX. PROSTHODONTICS, FIXED</b>						
*An additional charge for the cost of precious metal will be applied for any procedure using noble, high noble, or titanium metal not to exceed \$150 per unit.						
D6205	pontic – indirect resin based composite		250	250	250	250
D6210	pontic – cast high noble metal*	250	280	225	150	100
D6211	pontic – cast predominantly base metal	250	280	225	150	100
D6212	pontic – cast noble metal*	250	280	225	150	100
D6214	pontic – titanium*	250	280	225	150	100
D6240	pontic – porcelain fused to high noble metal*	250	280	225	150	100
D6241	pontic – porcelain fused to predominantly base metal	250	280	225	150	100
D6242	pontic – porcelain fused to noble metal*	250	280	225	150	100
D6245	pontic – porcelain/ceramic	250	325	285	215	215
D6250	pontic – resin with high noble metal*	250	225	225	150	100
D6251	pontic – resin with predominantly base metal	250	225	225	150	100
D6252	pontic – resin with noble metal*	250	225	225	150	100
D6253	provisional pontic – further treatment or completion of diagnosis necessary prior to final impression		175	175	175	175
D6545	retainer – cast metal for resin bonded fixed prosthesis		250	250	250	250
D6548	retainer – porcelain/ceramic for resin bonded fixed prosthesis		300	300	300	300
D6549	resin retainer – for resin bonded fixed prosthesis		85	85	85	85
D6600	retainer inlay – porcelain/ceramic, two surfaces		300	245	170	120
D6601	retainer inlay – porcelain/ceramic, three or more surfaces		300	245	170	120
D6602	retainer inlay – cast high noble metal, two surfaces*		185	160	135	100
D6603	retainer inlay – cast high noble metal, three or more surfaces*		185	160	135	100
D6604	retainer inlay – cast predominantly base metal, two surfaces		185	160	135	100
D6605	retainer inlay – cast predominantly base metal, three or more surfaces		185	160	135	100
D6606	retainer inlay – cast noble metal, two surfaces*		185	160	135	100
D6607	retainer inlay – cast noble metal, three or more surfaces*		185	160	135	100
D6608	retainer onlay – porcelain/ceramic, two surfaces		310	255	180	130
D6609	retainer onlay – porcelain/ceramic, three or more surfaces		310	255	180	130
D6610	retainer onlay – cast high noble metal, two surfaces*		185	160	135	100
D6611	retainer onlay – cast high noble metal, three or more surfaces*		185	160	150	100
D6612	retainer onlay – cast predominantly base metal, two surfaces		185	160	150	130
D6613	retainer onlay – cast predominantly base metal, three or more surfaces		185	160	150	130
D6614	retainer onlay – cast noble metal, two surfaces*		185	160	150	100
D6615	retainer onlay – cast noble metal, three or more surfaces*		185	160	150	100
D6624	retainer inlay – titanium*		280	225	150	100
D6634	retainer onlay – titanium*		280	225	150	100
D6710	retainer crown – indirect resin based composite		185	185	185	185
D6720	retainer crown – resin with high noble metal*	250	225	225	150	100
D6721	retainer crown – resin with predominantly base metal	250	225	225	150	100

<sup>1</sup> DBP will pay your office the difference between the Minimum Guarantee listed above and the Member's Copay.

Customer Service Phone Number 1-888-877-7828		Plan Name Agreement ID	Plan 450C	Plan 550C	Plan 650C	Plan 750C
			DMOCARG00005	DMOCARG00008	DMOCARG00009	DMOCARG00002
			Plan 450	Plan 550	Plan 650	Plan 750
			DMOCARG00011	DMOCARG00013	DMOCARG00015	DMOCARG00017
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
D6722	retainer crown – resin with noble metal*	250	225	225	150	100
D6740	retainer crown – porcelain/ceramic	250	325	285	215	215
D6750	retainer crown – porcelain fused to high noble metal*	250	280	225	150	100
D6751	retainer crown – porcelain fused to predominantly base metal	250	280	225	150	100
D6752	retainer crown – porcelain fused to noble metal*	250	280	225	150	100
D6780	retainer crown – ¾ cast high noble metal*		280	225	150	100
D6781	retainer crown – ¾ cast predominantly base metal		280	225	150	100
D6782	retainer crown – ¾ cast noble metal*		280	225	150	100
D6783	retainer crown – ¾ porcelain/ceramic		280	285	150	175
D6790	retainer crown – full cast high noble metal*	250	280	225	150	100
D6791	retainer crown – full cast predominantly base metal	250	280	225	150	100
D6792	retainer crown – full cast noble metal*	250	280	225	150	100
D6794	retainer crown – titanium*	250	280	225	150	100
D6920	connector bar		85	85	85	85
D6930	re-cement or re-bond fixed partial denture		10	0	0	0
D6940	stress breaker		135	105	110	110
D6980	fixed partial denture repair necessitated by restorative material failure		140	140	140	140
<b>X. ORAL &amp; MAXILLOFACIAL SURGERY</b>						
D7111	extraction, coronal remnants – primary tooth		5	0	0	0
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)		10	0	0	0
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		40	25	15	10
D7220	removal of impacted tooth – soft tissue		65	50	35	20
D7230	removal of impacted tooth – partially bony		105	75	50	40
D7240	removal of impacted tooth – completely bony		120	105	75	65
D7241	removal of impacted tooth – completely bony, with unusual surgical complications		140	125	95	75
D7250	removal of residual tooth roots (cutting procedure)		55	30	25	0
D7251	coronectomy – intentional partial tooth removal		40	25	15	10
D7261	primary closure of a sinus perforation		225	225	225	225
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth		95	50	50	45
D7280	exposure of an unerupted tooth		120	85	85	75
D7282	mobilization of erupted or malpositioned tooth to aid eruption		120	90	85	75
D7285	incisional biopsy of oral tissue – hard (bone, tooth)		115	125	0	0
D7286	incisional biopsy of oral tissue – soft		50	50	0	0
D7287	exfoliative cytological sample collection		20	20	20	20
D7288	brush biopsy – transepithelial sample collection		20	20	20	20
D7290	surgical repositioning of teeth		75	75	75	75
D7296	corticotomy - one to three teeth or tooth spaces, per quadrant		75	75	75	75
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant		75	75	75	75

<sup>1</sup> DBP will pay your office the difference between the Minimum Guarantee listed above and the Member's Copy.

Customer Service Phone Number 1-888-877-7828		Plan Name Agreement ID	Plan 450C	Plan 550C	Plan 650C	Plan 750C
			DMOCARG00005	DMOCARG00008	DMOCARG00009	DMOCARG00002
			Plan 450	Plan 550	Plan 650	Plan 750
			DMOCARG00011	DMOCARG00013	DMOCARG00015	DMOCARG00017
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
D7310	alveoplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		50	35	15	0
D7311	alveoplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		45	10	10	0
D7320	alveoplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		70	50	30	0
D7321	alveoplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		70	20	10	0
D7340	vestibuloplasty – ridge extension (secondary epithelialization)		215	215	215	215
D7350	vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)		670	670	670	670
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm		70	70	70	70
D7451	removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm		110	110	110	110
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm		100	100	100	100
D7461	removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm		125	125	125	125
D7471	removal of lateral exostosis (maxilla or mandible)		115	65	50	75
D7472	removal of torus palatinus		115	50	35	25
D7473	removal of torus mandibularis		115	50	35	25
D7485	reduction of osseous tuberosity		115	50	35	25
D7510	incision and drainage of abscess – intraoral soft tissue		50	25	15	10
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		75	25	15	10
D7520	incision and drainage of abscess – extraoral soft tissue		70	70	70	70
D7521	incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		190	190	190	190
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue		40	40	40	40
D7881	occlusal orthotic device adjustment		10	5	0	0
D7910	suture of recent small wounds up to 5 cm		25	25	15	10
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure		110	40	15	0
D7963	frenuloplasty		65	40	15	0
D7970	excision of hyperplastic tissue – per arch		60	50	25	25
D7971	excision of pericoronal gingiva		40	40	20	20
D7972	surgical reduction of fibrous tuberosity		100	95	85	40
<b>XII. ADJUNCTIVE GENERAL SERVICES</b>						
D9110	palliative (emergency) treatment of dental pain – minor procedure		10	10	10	5
D9211	regional block anesthesia		0	0	0	0
D9212	trigeminal division block anesthesia		0	0	0	0
D9215	local anesthesia in conjunction with operative or surgical procedures		0	0	0	0
D9219	evaluation for deep sedation or general anesthesia		10	0	0	0
D9222	deep sedation/general anesthesia – first 15 minutes		150	150	150	150
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment		75	75	75	75
D9230	inhalation of nitrous oxide/anoxiolysis, analgesia		30	30	30	30

<sup>1</sup> DBP will pay your office the difference between the Minimum Guarantee listed above and the Member's Copay.

**UNITEDHEALTHCARE / LINCOLN FINANCIAL GROUP DHMO  
 PRINCIPAL BENEFITS AND COVERAGES - MEMBER COPAYMENTS  
 EXHIBIT 2 - PART II**



Customer Service Phone Number 1-888-877-7828		Plan Name Agreement ID	Plan 450C	Plan 550C	Plan 650C	Plan 750C
			DMOCARG00005	DMOCARG00008	DMOCARG00009	DMOCARG00002
			Plan 450	Plan 550	Plan 650	Plan 750
			DMOCARG00011	DMOCARG00013	DMOCARG00015	DMOCARG00017
CDT codes not listed are not a covered benefit		Specialty Referral:	Pre-Auth	Pre-Auth	Pre-Auth	Pre-Auth
CDT CODE	Description	Minimum Guarantee <sup>1</sup>	Member Copayment			
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes		140	140	140	140
D9243	intravenous moderate (conscious) sedation/anesthesia – each subsequent 15 minute increment		70	70	70	70
D9248	non-intravenous conscious sedation		50	50	50	50
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		10	0	0	0
D9311	consultation with a medical health care professional		0	0	5	5
D9430	office visit for observation (during regularly scheduled hours) – no other services performed		0	0	5	5
D9440	office visit – after regularly scheduled hours		50	35	35	35
D9450	case presentation, detailed and extensive treatment planning		0	0	0	0
D9930	treatment of complications (post-surgical) – unusual circumstances, by report		0	0	0	0
D9943	occlusal guard adjustment		10	5	0	0
D9944	occlusal guard – hard appliance, full arch		105	75	100	85
D9945	occlusal guard – soft appliance, full arch		105	75	100	85
D9946	occlusal guard – hard appliance, partial arch		53	38	50	43
D9951	occlusal adjustment – limited		40	20	25	0
D9952	occlusal adjustment – complete		160	90	75	0
D9971	odontoplasty 1-2 teeth; includes removal of enamel projections		20	20	20	20
D9972	external bleaching – per arch – performed in office		125	125	125	125
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays		125	125	125	125
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
	Broken Appointment, with no prior notification at least 24 hrs before the scheduled appointment		15	20	10	10

**Footnotes:** Specialty family calendar year maximum does not apply to the listed plans. All copays listed are applicable in the specialist office with the exception of services provided by a Pedodontist. Listed Copayments do not apply to Covered Service provided by a Pedodontist. Instead, the parent or guardian is responsible for 49% of the pedodontist's contracted rate.

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

<sup>1</sup> DBP will pay your office the difference between the Minimum Guarantee listed above and the Member's Copay.

### 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. **PERIODIC ORAL EVALUATION** - Limited to 1 time per 6 months.
2. **INTRAORAL COMPLETE SERIES OR PANOREX** - Limited to 1 time in any 2-year period.
3. **BITEWING RADIOGRAPHS** - Limited to 1 series of 4 films per 6 months.
4. **DENTAL PROPHYLAXIS** - Limited to 1 time per 6 months.
5. **FLUORIDE TREATMENTS** - Limited to 1 time per calendar year.
6. **SCALING AND ROOT PLANING** - Limited to 4 quadrants per calendar year.
7. **PERIODONTAL MAINTENANCE PROCEDURES** - Limited to 1 time per 6 months, following active therapy, exclusive of gross debridement.
8. **REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS** - Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 years from initial or supplemental placement.
9. **REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS** - Replacement of complete dentures, and fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient noncompliance, the patient is liable for the cost of replacement.
10. **CROWNS** - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
11. **CROWNS** - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
12. **TEMPORARY CROWNS** - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
13. **INLAYS/ONLAYS** - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
14. **INLAYS/ONLAYS** - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
15. **STAINLESS STEEL CROWNS** - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.
16. **CROWNS, FIXED BRIDGES, AND IMPLANTS** - The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/ or pontics are done for a Member within a 12 month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Charges.
17. **POST AND CORES** - Covered only for teeth that have had root canal therapy.
18. **ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS** - Limited to repairs or adjustments performed more than 6 months after the initial insertion.
19. **INTRAVENOUS SEDATION OR GENERAL ANESTHESIA** – Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).
20. **ADJUNCTIVE** - Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesion, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
21. **REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS, ONLAYS, AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROSTHESIS** - Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implant crowns, implant prostheses previously submitted for payment under the plan is limited to 1 time per tooth per 5 years from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable orthodontic appliances.
22. **All Specialty Referral Services Must Be:**
  - (A) Pre-Authorized by us; and
  - (B) Coordinated by a Covered Person's Primary Care Dentist (PCD). Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred.

In order for specialty services to be Covered by this plan, the following referral process must be followed:

- A Covered Person's PCD must coordinate all Dental Services.



- When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization.
- If the PCD request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
- Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
- Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

### EXCLUSION OF BENEFITS

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

1. Dental Services that are not Necessary.
2. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
3. Any Dental Procedure not performed in a participating dental setting. This will not apply to Covered Emergency Dental Services.
4. Any Dental Procedure not directly associated with dental disease.
5. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
6. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
7. Cost 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 PCD, 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 Services.
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
10. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
11. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
12. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
13. Dental Services otherwise Covered under the Contract, but rendered after the date individual Coverage under the Contract terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Contract terminates.
14. 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.
15. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by a PCD; or (b) treatment by a specialist without referral from a PCD and our approval.
16. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
17. 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.
18. 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.
19. 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.
20. Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
21. Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.

**EXHIBIT 2**

22. 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.
23. 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.
24. 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
25. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Contract.
26. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

**ORTHODONTIC EXCLUSIONS & LIMITATIONS**

If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the Covered Person will be responsible for all costs associated with any orthodontic treatment. Orthodontic services are valid for authorized services rendered. If you terminate Coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. The following are not covered orthodontic benefits:
  - Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
  - Treatment in progress prior to the effective date of this coverage or services performed by outside laboratories
  - Extractions required for orthodontic purposes or surgical orthodontics or jaw repositioning
  - Myofunctional therapy, cleft palate, micrognathia, macroglossia, hormonal imbalances, and palatal expansion appliances
  - Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of treatment of accident
2. If a treatment plan is for less than 24 months, then a prorated portion of the full copayment shall apply.
3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions prearranged with the orthodontist.
4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.
5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for Comprehensive Orthodontic Treatment. If comprehensive treatment is necessary, and is completed within a 24 month period, the Copayments listed will apply. If necessary and active treatment extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge \$125 per month for active treatment extending beyond the 24 month benefit period.

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

CDT CODE	CDT DESCRIPTION	PLAN NAME:	SH 100 Retiree
	<b>CDT codes not listed are not a covered benefit</b>	<b>Agreement ID:</b>	<b>SFSGD0000002</b>
<b>SPECIALTY REFERRAL PROCESS (\$1000 Calendar Year Maximum excluding Orthodontia):</b>			<b>NTCV</b>
<b>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.</b>			<b>Member Copayment</b>
D0999	Encounter Fee		0
	Office Visit (see limitation at end of document)		5
	Initial charting with pocket depth summary		10
	Broken Appointment, with no prior notification at least 24 hrs before the scheduled appointment		0
<b>I. DIAGNOSTIC</b>			
D0120	periodic oral evaluation – established patient		8
D0140	limited oral evaluation – problem focused		11
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver		NTCV
D0150	comprehensive oral evaluation – new or established patient		10
D0160	detailed and extensive oral evaluation – problem focused, by report		12
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)		11
D0171	re-evaluation – post-operative office visit		NTCV
D0180	comprehensive periodontal evaluation – new or established patient		10
D0210	intraoral – complete series of radiographic images		22
D0220	intraoral – periapical first radiographic image		5
D0230	intraoral – periapical each additional radiographic image		3
D0240	intraoral – occlusal radiographic image		6
D0270	bitewing – single radiographic image		5
D0272	bitewings – two radiographic images		9
D0273	bitewings – three radiographic images		NTCV
D0274	bitewings – four radiographic images		11
D0330	panoramic radiographic image		18
D0460	pulp vitality tests		8
<b>II. PREVENTIVE</b>			
D1110	prophylaxis – adult		15
D1206	topical application of fluoride varnish		NTCV
D1208	topical application of fluoride – excluding varnish		NTCV
D1330	oral hygiene instructions		NTCV

CDT CODE	CDT DESCRIPTION	PLAN NAME:	SH 100 Retiree
	CDT codes not listed are not a covered benefit	Agreement ID:	SFSGD0000002
	<b>SPECIALTY REFERRAL PROCESS (\$1000 Calendar Year Maximum excluding Orthodontia):</b>		NTCV
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.			Member Copayment
<b>III. RESTORATIVE</b>			
<ul style="list-style-type: none"> <li>• If the services of a dental lab are required for any procedure, the member is responsible for the full laboratory cost, not to exceed the actual amount billed by the lab.</li> <li>• If alloy restorations are not provided or offered in the dental practice, payment for the posterior composites is to be based on the amalgam copayment.</li> </ul>			
D2140	amalgam – one surface, primary or permanent		50
D2150	amalgam – two surfaces, primary or permanent		59
D2160	amalgam – three surfaces, primary or permanent		70
D2161	amalgam – four or more surfaces, primary or permanent		82
D2330	resin-based composite – one surface, anterior		64
D2331	resin-based composite – two surfaces, anterior		75
D2332	resin-based composite – three surfaces, anterior		84
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		94
D2391	resin-based composite – one surface, posterior		66
D2392	resin-based composite – two surfaces, posterior		85
D2393	resin-based composite – three surfaces, posterior		102
D2394	resin-based composite – four or more surfaces, posterior		117
D2510	inlay – metallic – one surface		NTCV
D2520	inlay – metallic – two surfaces		NTCV
D2530	inlay – metallic – three or more surfaces		NTCV
D2542	onlay – metallic – two surfaces		NTCV
D2543	onlay – metallic – three surfaces		NTCV
D2544	onlay – metallic – four or more surfaces		NTCV
D2710	crown – resin-based composite (indirect)		172
D2712	crown – ¾ resin-based composite (indirect)		172
D2720	crown – resin with high noble metal		438
D2721	crown – resin with predominantly base metal		385
D2722	crown – resin with noble metal		438
D2740	crown – porcelain/ceramic		487
D2750	crown – porcelain fused to high noble metal		469
D2751	crown – porcelain fused to predominantly base metal		447
D2752	crown – porcelain fused to noble metal		455
D2780	crown – ¾ cast high noble metal		459
D2781	crown – ¾ cast predominantly base metal		459
D2782	crown – ¾ cast noble metal		459

CDT CODE	CDT DESCRIPTION	PLAN NAME:	SH 100 Retiree
	<b>CDT codes not listed are not a covered benefit</b>	<b>Agreement ID:</b>	<b>SFSGD0000002</b>
<b>SPECIALTY REFERRAL PROCESS (\$1000 Calendar Year Maximum excluding Orthodontia):</b>			<b>NTCV</b>
<b>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.</b>			<b>Member Copayment</b>
D2783	crown – ¾ porcelain/ceramic		366
D2790	crown – full cast high noble metal		461
D2791	crown – full cast predominantly base metal		428
D2792	crown – full cast noble metal		455
D2794	crown – titanium		428
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		33
D2920	re-cement or re-bond crown		33
D2931	prefabricated stainless steel crown – permanent tooth		105
D2932	prefabricated resin crown		105
D2940	protective restoration		30
D2941	interim therapeutic restoration – primary dentition		NTCV
D2950	core buildup, including any pins when required		NTCV
D2951	pin retention – per tooth, in addition to restoration		23
D2952	post and core in addition to crown, indirectly fabricated		135
D2953	each additional indirectly fabricated post – same tooth		108
D2954	prefabricated post and core in addition to crown		108
D2957	each additional prefabricated post – same tooth		87
D2971	additional procedures to construct new crown under existing partial denture framework		100
D2975	coping		50
<b>IV. ENDODONTICS</b>			
• <b>Surgical services include routine post-operative care</b>			
D3110	pulp cap – direct (excluding final restoration)		27
D3120	pulp cap – indirect (excluding final restoration)		45
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament		46
D3310	endodontic therapy, anterior tooth (excluding final restoration)		308
D3320	endodontic therapy, premolar tooth (excluding final restoration)		364
D3330	endodontic therapy, molar tooth (excluding final restoration)		490
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		245
D3346	retreatment of previous root canal therapy – anterior		NTCV
D3347	retreatment of previous root canal therapy – premolar		NTCV
D3348	retreatment of previous root canal therapy – molar		NTCV
D3410	apicoectomy – anterior		NTCV

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<b>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.</b>			<b>Member Copayment</b>
D3421	apicoectomy – premolar (first root)		NTCV
D3425	apicoectomy – molar (first root)		NTCV
D3426	apicoectomy (each additional root)		NTCV
D3427	periradicular surgery without apicoectomy		NTCV
D3430	retrograde filling – per root		NTCV
D3950	canal preparation and fitting of preformed dowel or post		60
<b>V. PERIODONTICS</b>			
• Surgical services include routine post-operative care			
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant		NTCV
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant		NTCV
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant		NTCV
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant		NTCV
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant		NTCV
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant		NTCV
D4341	periodontal scaling and root planing – four or more teeth per quadrant		90
D4342	periodontal scaling and root planing – one to three teeth per quadrant		45
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit		50
D4910	periodontal maintenance		54
D4921	gingival irrigation - per quadrant		NTCV
<b>VI. PROSTHODONTICS (REMOVABLE)</b>			
• If the services of a dental lab are required for any procedure, you are responsible for the full laboratory cost, not to exceed the actual amount billed by the lab.			
• Includes post-delivery care and adjustments for the first 6 months (at the office delivering the removable prosthesis).			
D5110	complete denture – maxillary		528
D5120	complete denture – mandibular		536
D5130	immediate denture – maxillary		540
D5140	immediate denture – mandibular		534
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		480
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		477
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		681
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		690

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<b>SPECIALTY REFERRAL PROCESS (\$1000 Calendar Year Maximum excluding Orthodontia):</b>			<b>NTCV</b>
<b>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.</b>			<b>Member Copayment</b>
D5225	maxillary partial denture – flexible base (including any clasps, rests and teeth)		480
D5226	mandibular partial denture – flexible base (including any clasps, rests and teeth)		477
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary		496
D5283	removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular		496
D5410	adjust complete denture – maxillary		30
D5411	adjust complete denture – mandibular		30
D5421	adjust partial denture – maxillary		30
D5422	adjust partial denture – mandibular		30
D5511	repair broken complete denture base, mandibular		64
D5512	repair broken complete denture base, maxillary		64
D5520	replace missing or broken teeth – complete denture (each tooth)		54
D5611	repair resin partial denture base, mandibular		69
D5612	repair resin partial denture base, maxillary		69
D5621	repair cast partial framework, mandibular		63
D5622	repair cast partial framework, maxillary		63
D5630	repair or replace broken clasp – per tooth		77
D5640	replace broken teeth – per tooth		60
D5650	add tooth to existing partial denture		78
D5660	add clasp to existing partial denture – per tooth		90
D5670	replace all teeth and acrylic on cast metal framework (maxillary)		341
D5671	replace all teeth and acrylic on cast metal framework (mandibular)		345
D5730	reline complete maxillary denture (chairside)		111
D5731	reline complete mandibular denture (chairside)		108
D5740	reline maxillary partial denture (chairside)		89
D5741	reline mandibular partial denture (chairside)		105
D5750	reline complete maxillary denture (laboratory)		165
D5751	reline complete mandibular denture (laboratory)		158
D5760	reline maxillary partial denture (laboratory)		159
D5761	reline mandibular partial denture (laboratory)		162
D5850	tissue conditioning, maxillary		NTCV
D5851	tissue conditioning, mandibular		NTCV
D5863	overdenture - complete maxillary		NTCV
D5864	overdenture - complete mandibular		NTCV



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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.			Member Copayment
D5865	overdenture - partial maxillary		NTCV
D5866	overdenture - partial mandibular		NTCV
<b>VII. MAXILLOFACIAL PROSTHETICS</b>			
• If the services of a dental lab are required for any procedure, the member is responsible for the full laboratory cost, not to exceed the actual amount billed by the lab.			
D6210	pontic – cast high noble metal		438
D6211	pontic – cast predominantly base metal		405
D6212	pontic – cast noble metal		435
D6214	pontic – titanium		405
D6240	pontic – porcelain fused to high noble metal		455
D6241	pontic – porcelain fused to predominantly base metal		420
D6242	pontic – porcelain fused to noble metal		441
D6245	pontic – porcelain/ceramic		455
D6250	pontic – resin with high noble metal		487
D6251	pontic – resin with predominantly base metal		430
D6252	pontic – resin with noble metal		430
D6602	retainer inlay – cast high noble metal, two surfaces		NTCV
D6603	retainer inlay – cast high noble metal, three or more surfaces		NTCV
D6604	retainer inlay – cast predominantly base metal, two surfaces		NTCV
D6605	retainer inlay – cast predominantly base metal, three or more surfaces		NTCV
D6606	retainer inlay – cast noble metal, two surfaces		NTCV
D6607	retainer inlay – cast noble metal, three or more surfaces		NTCV
D6624	retainer inlay – titanium		NTCV
D6720	retainer crown – resin with high noble metal		434
D6721	retainer crown – resin with predominantly base metal		434
D6722	retainer crown – resin with noble metal		434
D6740	retainer crown – porcelain/ceramic		487
D6750	retainer crown – porcelain fused to high noble metal		456
D6751	retainer crown – porcelain fused to predominantly base metal		438
D6752	retainer crown – porcelain fused to noble metal		455
D6780	retainer crown – ¾ cast high noble metal		438
D6781	retainer crown – ¾ cast predominantly base metal		459
D6782	retainer crown – ¾ cast noble metal		459



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<b>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.</b>			<b>Member Copayment</b>
D6783	retainer crown – ¾ porcelain/ceramic		459
D6790	retainer crown – full cast high noble metal		455
D6791	retainer crown – full cast predominantly base metal		428
D6792	retainer crown – full cast noble metal		438
D6794	retainer crown – titanium		428
D6930	re-cement or re-bond fixed partial denture		43
<b>X. ORAL AND MAXILLOFACIAL SURGERY</b>			
• Includes local anesthesia, suturing, and routine post-operative care.			
D7111	extraction, coronal remnants – primary tooth		51
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)		54
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		NTCV
D7220	removal of impacted tooth – soft tissue		NTCV
D7230	removal of impacted tooth – partially bony		NTCV
D7240	removal of impacted tooth – completely bony		NTCV
D7250	removal of residual tooth roots (cutting procedure)		NTCV
D7285	incisional biopsy of oral tissue – hard (bone, tooth)		NTCV
D7286	incisional biopsy of oral tissue – soft		NTCV
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		NTCV
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		NTCV
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		NTCV
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		NTCV
D7471	removal of lateral exostosis (maxilla or mandible)		NTCV
D7472	removal of torus palatinus		NTCV
D7473	removal of torus mandibularis		NTCV
D7485	reduction of osseous tuberosity		NTCV
D7510	incision and drainage of abscess – intraoral soft tissue		65
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		98
D7520	incision and drainage of abscess – extraoral soft tissue		NTCV
D7521	incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		NTCV
<b>XII. ADJUNCTIVE GENERAL SERVICES</b>			
D9110	palliative (emergency) treatment of dental pain – minor procedure		38
D9215	local anesthesia in conjunction with operative or surgical procedures		0



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<b>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.</b>			<b>Member Copayment</b>
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		NTCV
D9430	office visit for observation (during regularly scheduled hours) – no other services performed		5
D9440	office visit – after regularly scheduled hours		50
D9450	case presentation, detailed and extensive treatment planning		NTCV
D9951	occlusal adjustment – limited		35

**OFFICE VISIT LIMITATIONS:**

- A) The copayment specified in this schedule for office visits is limited to 4 per year, per person. Office visits beyond 4 per year are at no charge. This copayment is due in addition to any other copayment(s) specified for procedures or services rendered.
- B) The fee specified in this schedule for oral examinations is limited to four per year, per member. This fee(s) is due in addition to any other fee(s) specified for procedures or services rendered. Oral examinations beyond four per year are provided at no charge.
- C) For fillings, the office visit copayment is due only once per quadrant, even if fillings are done on separate visits.
- D) For root canals and crowns, the office visit copayment is due only once per procedure, regardless of the number of visits necessary to complete that procedure. For multiple procedures, the office visit copayment is due once for each procedure.
- E) Covered general dental services are unlimited when prescribed and performed by the assigned dental office. A member may be referred to a dental specialist for procedures that are beyond the scope of the general dentist.

**FOOTNOTE:** Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade. Members 16 years of age and older are limited to 7 crowns and/or pontics in any 12-month period and any single fixed bridge is limited to 4 units in length. The supplemental reimbursement is in addition to this amount.

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

**LIMITATION OF BENEFITS**

1. **PROPHYLAXIS** - Routine cleaning of teeth, including scaling and polishing procedures to remove coronal plaque, calculus and stains, is an allowable preventive benefit once every 6 months.
2. **RADIOGRAPHS** Full Mouth (X-rays) are limited to once in any 2-year period.  
**BITEWING X-RAYS** are limited to no more than 1 series of 4 films in any 6-month period.
3. **FLUORIDE TREATMENTS** are limited to only once per calendar year.
4. **PERIODONTAL SCALING AND ROOT PLANING** - Both procedures are allowable only when the need can be demonstrated radiographically and/or by pocket charting. There is a maximum of 4 quadrants per calendar year, and **ONLY** two quadrants are allowable at an appointment.
5. **PERIODONTAL MAINTENANCE PROCEDURES** are a benefit following active therapy (previous to periodontal treatment) once every 6 months at the Specialist's office when referred by your Assigned Dental Provider Group, or provided at your Assigned Dental Provider Group.
6. **OFFICE VISITS**
  - A) The copayment fee for an office visit is limited to 4 per year, per member. Office visits beyond 4 per year are provided at no charge.
  - B) The office visit for fillings is due only once per quadrant, even oif fillings are done on separate visits.
  - C) The office visit fee for root canals and crowns is due only once per procedure, regardless of the number of visits necessary to complete that procedure.
7. **PROSTHETICS**
  - A. **REMOVABLE PROSTHETICS**

Temporary or Transitional Dentures - Temporary or transitional full dentures are not a covered benefit. However, with some benefit packages, an exception is made for an

    - 1) anterior stayplate when this interim appliance either:
      - a) Replaces natural, permanent, anterior teeth, during the healing period immediately after extraction or traumatic tooth loss; or
      - b) Replaces extracted or lost natural, permanent, anterior teeth for Members under 16 years of age.Laboratory Upgrades including specialized services for Dentures are not covered. Fees to the Member for upgrades will be limited to the additional laboratory fee charged to
    - 2) the dentist by the dental laboratory for the upgrade. Upgrades include, but are not limited to:
      - a) Precious metal for removable appliance framework or a metal base for a full denture;
      - b) Personalization and characterization;
      - c) Specialized materials;
      - d) Specialized services or techniques involving precision attachments or stress breakers.
    - 3) Dentures, Replacement, Repairs and Relines
      - a) For existing full or partial dentures, the addition of new denture teeth is covered if a natural tooth or a denture tooth is lost. Replacement of an existing full or partial denture is covered.
      - b) If an existing permanent denture needs to be repaired and/or relined to be made serviceable, then repairs and/or relines are also a benefit. The addition of denture teeth, repairs and relines of secondary ("back-up," "spare" or "temporary") dentures are not covered benefits.
      - c) Denture adjustments - Adjustments for new dentures are included in the Copayment for the denture for 6 months following delivery. For existing dentures, or new dentures after the initial 6 months, the Member is responsible for the listed Copayment for a denture adjustment. Adjustments of secondary ("back-up" or "spare") dentures are not a covered benefit.
  - B. **FIXED PROSTHETICS:**
    - 1) A fixed bridge is a benefit to replace missing natural teeth, unless based on professionally recognized standards:
      - a) The clinical condition of the teeth that would support the bridge is unfavorable.
      - b) There are inadequate teeth available to support the bridge.
      - c) The same dental arch has a serviceable existing partial denture to which additional denture teeth may be added to replace the missing natural teeth.
      - d) The new bridge would replace an existing bridge that is still serviceable.

- e) A bridge would be used only to realign malaligned teeth.
- 2) A fixed bridge is a benefit to replace missing natural teeth, unless:
  - a) The requested service is for a new bridge and a new partial denture in the same arch. In such cases the Covered Service is for a partial denture that would replace all missing teeth in the arch or multiple bridges.
  - b) If an unserviceable existing bridge is less than 5 years old, even if unserviceable, its replacement is not a covered dental service
  - b) A Member under 16 years of age loses a permanent tooth; in which case an anterior stayplate or space maintainer would be the covered benefit to replace the missing tooth. If the bridge is placed, patient or guardian must pay the dentist's billed charges.
  - c) The bridge would be supported in whole or in part by dental implants, or acid-etched resin bridge retainers (a "Maryland" bridge). A bridge would be used only to realign malaligned teeth.
  - e) It is a long spanning bridge (anything beyond 4 abutments and/or pontics).
  - f) The bridge would have an abutment (support) only on 1 side (cantilever bridge).
    - Fees for upgrades such as precious or semiprecious metal alloys will be limited to the additional fee charged to the network dentist by the dental laboratory for the
    - g) upgrade
- C. **SINGLE CROWNS, INLAYS AND ONLAYS**

Single crowns, inlays and onlays will be covered when there is not enough retentive quality left in a tooth to hold a filling, or if the tooth requires cuspal protection to avoid an unacceptable risk of tooth fracture. The use of specialized materials, i.e., precious or semi-precious metals in crowns, is considered a laboratory upgrade, which the dentist may Porcelain, porcelain-fused-to-metal (PFM), and cast metal crowns are not a benefit for children under 16 years of age. The benefit in such cases is a prefabricated stainless

  - 1) steel or resin crown. If a porcelain, PFM, or cast metal crown is performed, the parent or guardian must pay the Provider's Billed Charges.
  - 2) If a porcelain, PFM or cast metal crown is less than 5 years old, even if unserviceable, its replacement is not a covered dental service
  - Replacement of an inlay, onlay, porcelain or PFM crown is a covered benefit as long as the existing restoration is unserviceable, and can not be made serviceable, as
  - 3) determined by your assigned dentist.

For crowns and fixed bridges, the maximum benefit within a 12-month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12-month period, the dentist's fee for any additional crowns within that period would not be limited to the
  - 4) listed Copayment, but instead can reflect the Dentist's Billed Charges.
    - Fees for upgrades such as precious or semiprecious metal alloys will be limited to the additional fee charged to the network dentist by the dental laboratory for the upgrade
    - 5)
- 8. **OCCUSAL EQUILIBRATION** - This means the reshaping of the biting surfaces of the teeth to create harmonious contact and relationships between teeth in the upper and lower jaw. Adjustment of the bite on a new restoration, crown, bridge, and denture will be provided at no additional charge if performed by the UHC Participating Provider who provided the restoration service. However, the correction of occlusion on natural teeth or existing restorations is not a Covered Service.
- 9. **DOWEL POSTS AND PINS** - Dowel posts are a benefit for teeth that have had root canal therapy and lack sufficient structure to otherwise support and retain a crown. Pins are a separate Covered Service if deemed necessary by a UHC Participating Provider to provide adequate retention of a restoration.
- 10. **SPECIALTY REFERRAL** - The BENEFIT of dental treatment by a Specialist is limited to:
  - Dental plans which include specialty referral benefits
  - Covered dental services performed by an oral surgeon, endodontist and periodontist that are beyond the scope of practice of a general dentist
  - Pedodontic referrals apply to all children through age 18 as necessary
  - Services by an orthodontist, if the Member's Dental Plan specifically includes UHC's orthodontic benefit.
  - Specialty Referral Maximum - UHC will not pay more than the specialty family calendar year maximum listed in the Schedule of Benefits, if applicable. Any specialty fees for a family over and above the maximum during a calendar year are not covered by UHC, and are the responsibility of the Member.
- 11. **RESTORATIONS AND DENTAL PROSTHETICS**

**EXHIBIT 2**

- A. Restorations and/or fixed or removable prosthetics needed solely to increase vertical dimension or restore the occlusal plane are not Covered Services. To restore the occlusal plane means oral rehabilitation using crown(s), bridge(s), filling(s), and/or denture(s) to establish an altered bite or relationship between the jaws.
  - B. Composite restorations on posterior teeth may not be a benefit for all plans. Please refer to your Schedule of Benefits.
12. **I.V. SEDATION OR GENERAL ANESTHESIA** - Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).

**EXCLUSION OF BENEFITS**

**The following procedures and services are excluded and not Covered Services:**

- 1. Specialty referral benefits, unless otherwise indicated in the Schedule of Benefits, are not covered.
- 2. Services provided by a prosthodontist are not covered.
- 3. Cosmetic dental care is not covered.
- 4. Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Member's Assigned Dental Provider Group, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
- 5. Treatment of fractured bones and dislocated joints is not covered.
- 6. Lost or stolen dentures are not covered.
- 7. Crowns or bridgework that are lost, stolen, or damaged due to Member abuse, misuse or neglect are not covered, unless the crown or bridge became dislodged because of recurrent dental caries, tooth fracture, substandard tooth preparation, or poor margins (as previously determined in an examination by the Assigned Dental Provider Group or based upon a review of a pre-existing radiograph).
- 8. Lost, stolen or broken orthodontic appliances are not covered.
- 9. Services that are provided to the Member by a state government or agency thereof, or are provided without cost to the Member by a municipality, county or other subdivision are not covered.
- 10. Charges for services rendered after termination of the Member's eligibility under the Dental Plan are not covered.
- 11. Work-in-progress: Dental expenses incurred in connection with any portion of the dental services started prior to the effective date of coverage are excluded. The completion of dental or orthodontia services started before the Member's application date or effective date of coverage with UHC, whichever is earlier, or started by a Non-Participating Provider without the prior approval of UHC is not covered. This exclusion does not apply to a current Member:
  - A. who has temporary restorative services
  - B. whose tooth was opened and medicated while out-of-area or when the assigned dentist is unavailable to render care.
- 12. The treatment of congenital and/or developmental malformations, which includes the treatment of congenitally missing and extra, supernumerary teeth and related pathology is not covered.
- 13. The treatment of non-dentigerous cysts, benign and malignant tumors, neoplasms, and dysplasias is not covered.
- 14. Dental ridge augmentation, vestibuloplasties, and the excision of benign hyperplastic tissue are not covered.
- 15. Prescription drugs and over-the-counter medicines are not covered.
- 16. Any dental procedure unable to be performed in the Member's Assigned Dental Provider Group because of the Member's general health and physical limitations is not covered unless an alternative is recommended by the Assigned Dental Provider Group and the Member's physician and authorized by the Plan.
- 17. Oral surgery and procedures performed in connection with orthodontic treatment, which include, but are not limited to: orthodontic extraction, serial extraction, orthognathic surgery, transeptal fiberotomy, gingivectomy, and surgery to uncover impacted teeth are not covered.
- 18. Services rendered by a dental office other than the Member's Assigned Dental Provider Group are not covered. An exception is made for Emergency Dental Care, as defined in this Combined Evidence of Coverage and Disclosure Form.
- 19. The placement, maintenance, and removal of implants, or crowns and fixed prosthetics supported by implants, are not covered.

**EXHIBIT 2**

20. Restorations to replace or stabilize tooth structure lost solely by abrasion or erosion are not covered. Restorations of natural teeth other than those noted herein are not covered. Such treatment includes, but is not limited to, replacing or stabilizing tooth structure loss by abrasion or erosion.
21. Periodontal splinting/grafting is not covered.
22. Amalgam restorations, with new reiterations of a different material solely to eliminate the presence of amalgam are not covered.
23. Restorations and dental prosthetics that are done solely to alter the vertical dimension of occlusion, alter the plane of occlusion, modify a parafunctional habit, and/or treat temporomandibular joint dysfunction and/or myofascial pain syndrome are not Covered Services. If performed, the patient must pay the dentist's Billed Charges. These services include:
  - Realignment of teeth
  - Gnathologic recording
  - Occlusal splints and night guards
  - Overlays, implant supported partial dentures and overdentures
  - The replacement of otherwise serviceable existing restorations and dental prosthetics
  - Precision attachments and stressbreakers
24. Dental services that the Plan or Participating Provider determines not to be medically necessary or consistent with good professional practice are not covered.
25. Dental services that would not be consistent with the individual Member's dental needs and/or professional recognized standards of dental therapeutics for that Member are not covered.
26. The premature extraction of asymptomatic or non-pathologic impacted teeth at an early stage of tooth development, which, if allowed to further develop and erupt, would reduce the likelihood of needing a more invasive surgery and/or experiencing post-operative complications.
27. Adjunctive dental services that are performed solely to facilitate the performance of another non-Covered Service.
28. Medical services for treatment of fractures, dislocations, tumors, non-dentigerous cysts, and neoplasms, and other medically necessary surgeries of the jaws or related joints are not covered. Requests for such services should be submitted to the Member's full service medical health plan.
29. Relative analgesia (N2O2 - nitrous oxide) is not covered.

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

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<b>† 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.</b>			
<b>I. DIAGNOSTIC</b>			
D0120	periodic oral evaluation – established patient	0	
D0140	limited oral evaluation – problem focused	0	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0	
D0150	comprehensive oral evaluation – new or established patient	0	
D0160	detailed and extensive oral evaluation – problem focused, by report	0	
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)	0	
D0171	re-evaluation – post-operative office visit	0	
D0180	comprehensive periodontal evaluation – new or established patient	0	
D0210	intraoral – complete series of radiographic images	0	
D0220	intraoral – periapical first radiographic image	0	
D0230	intraoral – periapical each additional radiographic image	0	
D0240	intraoral – occlusal radiographic image	0	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0	
D0251	extra-oral posterior dental radiographic image	0	
D0270	bitewing – single radiographic image	0	
D0272	bitewings – two radiographic images	0	
D0273	bitewings – three radiographic images	0	
D0274	bitewings – four radiographic images	0	
D0277	vertical bitewings – 7 to 8 radiographic images	0	
D0310	sialography	0	
D0320	temporomandibular joint arthrogram, including injection	0	
D0322	tomographic survey	0	
D0330	panoramic radiographic image	0	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	0	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0	
D0351	3D photographic image	0	
D0460	pulp vitality tests	0	
D0470	diagnostic casts	0	
D0502	other oral pathology procedures, by report	0	

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D0601	caries risk assessment and documentation, with a finding of low risk	0	
D0602	caries risk assessment and documentation, with a finding of moderate risk	0	
D0603	caries risk assessment and documentation, with a finding of high risk	0	
D0999†	Office Visit Charge, per visit (Encounter Fee)	0	2
<b>II. PREVENTIVE</b>			
D1110	prophylaxis – adult	0	
D1120	prophylaxis – child	0	
D1206	topical application of fluoride varnish	0	
D1208	topical application of fluoride – excluding varnish	0	
D1310	nutritional counseling for control of dental disease	0	
D1320	tobacco counseling for the control and prevention of oral disease	0	
D1330	oral hygiene instructions	0	
D1351	sealant – per tooth	0	13
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth	0	13
D1353	sealant repair – per tooth	0	
D1354	interim caries arresting medicament application - per tooth <i>(Benefit under 2019 EHB plan only)</i>	0	
D1510	space maintainer – fixed, unilateral	0	45
D1516	space maintainer – fixed – bilateral, maxillary	0	45
D1517	space maintainer – fixed – bilateral, mandibular	0	45
D1520	space maintainer – removable – unilateral	0	60
D1526	space maintainer – removable – bilateral, maxillary	0	60
D1527	space maintainer – removable – bilateral, mandibular	0	60
D1550	re-cement or re-bond space maintainer	0	20
D1555	removal of fixed space maintainer	0	20
D1575	distal shoe space maintainer – fixed – unilateral	0	
<b>III. RESTORATIVE</b>			
D2140	amalgam – one surface, primary or permanent	25	
D2150	amalgam – two surfaces, primary or permanent	30	
D2160	amalgam – three surfaces, primary or permanent	40	
D2161	amalgam – four or more surfaces, primary or permanent	45	
D2330	resin-based composite – one surface, anterior	30	
D2331	resin-based composite – two surfaces, anterior	45	



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D2332	resin-based composite – three surfaces, anterior	55	
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)	60	
D2390	resin-based composite crown, anterior	50	
D2391	resin-based composite – one surface, posterior	30	55
D2392	resin-based composite – two surfaces, posterior	40	60
D2393	resin-based composite – three surfaces, posterior	50	90
D2394	resin-based composite – four or more surfaces, posterior	70	100
D2710	crown – resin-based composite (indirect)	140	185
D2712	crown – ¾ resin-based composite (indirect)	190	
D2721	crown – resin with predominantly base metal	300	325
D2740	crown – porcelain/ceramic	300	405
D2751	crown – porcelain fused to predominantly base metal	300	325
D2781	crown – ¾ cast predominantly base metal	300	355
D2783	crown – ¾ porcelain/ceramic	310	395
D2791	crown – full cast predominantly base metal	300	325
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	25	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	25	
D2920	re-cement or re-bond crown	25	
D2921	reattachment of tooth fragment, incisal edge or cusp	45	
D2929	prefabricated porcelain/ceramic crown – primary tooth	95	
D2930	prefabricated stainless steel crown – primary tooth	65	
D2931	prefabricated stainless steel crown – permanent tooth	75	
D2932	prefabricated resin crown	75	
D2933	prefabricated stainless steel crown with resin window	80	
D2940	protective restoration	25	
D2941	interim therapeutic restoration – primary dentition	30	
D2949	restorative foundation for an indirect restoration	45	
D2950	core buildup, including any pins when required	20	55
D2951	pin retention – per tooth, in addition to restoration	25	
D2952	post and core in addition to crown, indirectly fabricated	100	
D2953	each additional indirectly fabricated post – same tooth	30	55
D2954	prefabricated post and core in addition to crown	90	

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D2955	post removal	60	
D2957	each additional prefabricated post – same tooth	35	
D2971	additional procedures to construct new crown under existing partial denture framework	35	70
D2980	crown repair necessitated by restorative material failure	50	
D2999	unspecified restorative procedure, by report	40	
<b>IV. ENDODONTICS</b>			
D3110	pulp cap – direct (excluding final restoration)	20	
D3120	pulp cap – indirect (excluding final restoration)	25	
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	40	
D3221	pulpal debridement, primary and permanent teeth	40	
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	60	
D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	55	
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	55	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	195	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	235	275
D3330	endodontic therapy, molar tooth (excluding final restoration)	300	410
D3331	treatment of root canal obstruction; non-surgical access	50	110
D3333	internal root repair of perforation defects	80	110
D3346	retreatment of previous root canal therapy – anterior	240	
D3347	retreatment of previous root canal therapy – premolar	295	
D3348	retreatment of previous root canal therapy – molar	365	420
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	85	90
D3352	apexification/recalcification – interim medication replacement	45	90
D3410	apicoectomy – anterior	240	
D3421	apicoectomy – premolar (first root)	250	
D3425	apicoectomy – molar (first root)	275	
D3426	apicoectomy (each additional root)	110	
D3427	periradicular surgery without apicoectomy	160	
D3430	retrograde filling – per root	90	
D3910	surgical procedure for isolation of tooth with rubber dam	30	
D3999	unspecified endodontic procedure, by report	100	

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<b>V. PERIODONTICS</b>			
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	150	
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	50	90
D4249	clinical crown lengthening – hard tissue	165	
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	265	405
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	140	325
D4265	biologic materials to aid in soft and osseous tissue regeneration	80	
D4341	periodontal scaling and root planing – four or more teeth per quadrant	55	60
D4342	periodontal scaling and root planing – one to three teeth per quadrant	30	55
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	220	
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	40	60
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	10	
D4910	periodontal maintenance	30	50
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	15	
D4999	unspecified periodontal procedure, by report	350	
<b>VI. PROSTHODONTICS, REMOVABLE</b>			
D5110	complete denture – maxillary	300	400
D5120	complete denture – mandibular	300	400
D5130	immediate denture – maxillary	300	415
D5140	immediate denture – mandibular	300	415
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	300	375
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	300	375
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	335	475
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	335	475
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	275	
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	275	
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	330	

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D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	330	
D5410	adjust complete denture – maxillary	20	
D5411	adjust complete denture – mandibular	20	
D5421	adjust partial denture – maxillary	20	
D5422	adjust partial denture – mandibular	20	
D5511	repair broken complete denture base, mandibular	40	
D5512	repair broken complete denture base, maxillary	40	
D5520	replace missing or broken teeth – complete denture (each tooth)	40	
D5611	repair resin partial denture base, mandibular	40	
D5612	repair resin partial denture base, maxillary	40	
D5621	repair cast partial framework, mandibular	40	
D5622	repair cast partial framework, maxillary	40	
D5630	repair or replace broken clasp – per tooth	50	
D5640	replace broken teeth – per tooth	35	40
D5650	add tooth to existing partial denture	35	45
D5660	add clasp to existing partial denture – per tooth	60	
D5730	reline complete maxillary denture (chairside)	60	75
D5731	reline complete mandibular denture (chairside)	60	75
D5740	reline maxillary partial denture (chairside)	60	75
D5741	reline mandibular partial denture (chairside)	60	75
D5750	reline complete maxillary denture (laboratory)	90	95
D5751	reline complete mandibular denture (laboratory)	90	95
D5760	reline maxillary partial denture (laboratory)	80	95
D5761	reline mandibular partial denture (laboratory)	80	95
D5850	tissue conditioning, maxillary	30	
D5851	tissue conditioning, mandibular	30	
D5862	precision attachment, by report	90	
D5863	overdenture - complete maxillary	300	
D5864	overdenture - complete mandibular	300	
D5865	overdenture - partial maxillary	300	
D5866	overdenture - partial mandibular	300	

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D5899	unspecified removable prosthodontic procedure, by report	350	
<b>VII. MAXILLOFACIAL PROSTHETICS - COVERED ONLY WHEN MEDICALLY NECESSARY</b>			
D5911	facial moulage (sectional)	285	
D5912	facial moulage (complete)	350	
D5913	nasal prosthesis	350	
D5914	auricular prosthesis	350	
D5915	orbital prosthesis	350	
D5916	ocular prosthesis	350	
D5919	facial prosthesis	350	
D5922	nasal septal prosthesis	350	
D5923	ocular prosthesis, interim	350	
D5924	cranial prosthesis	350	
D5925	facial augmentation implant prosthesis	200	
D5926	nasal prosthesis, replacement	200	
D5927	auricular prosthesis, replacement	200	
D5928	orbital prosthesis, replacement	200	
D5929	facial prosthesis, replacement	200	
D5931	obturator prosthesis, surgical	350	
D5932	obturator prosthesis, definitive	350	
D5933	obturator prosthesis, modification	150	
D5934	mandibular resection prosthesis with guide flange	350	
D5935	mandibular resection prosthesis without guide flange	350	
D5936	obturator prosthesis, interim	350	
D5937	trismus appliance (not for TMD treatment)	85	
D5951	feeding aid	135	
D5952	speech aid prosthesis, pediatric	350	
D5953	speech aid prosthesis, adult	350	
D5954	palatal augmentation prosthesis	135	
D5955	palatal lift prosthesis, definitive	350	
D5958	palatal lift prosthesis, interim	350	
D5959	palatal lift prosthesis, modification	145	
D5960	speech aid prosthesis, modification	145	

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D5982	surgical stent	70	
D5983	radiation carrier	55	
D5984	radiation shield	85	
D5985	radiation cone locator	135	
D5986	fluoride gel carrier	35	
D5987	commissure splint	85	
D5988	surgical splint	95	
D5991	vesiculobullous disease medicament carrier	70	
D5999	unspecified maxillofacial prosthesis, by report	350	
<b>VIII. IMPLANT SERVICES</b>			
D6010	surgical placement of implant body: endosteal implant	350	1,035
D6011	second stage implant surgery	350	600
D6013	surgical placement of a mini-implant	350	750
D6040	surgical placement: eosteal implant	350	1,035
D6050	surgical placement: transosteal implant	350	1,035
D6052	semi-precision attachment abutment	350	
D6055	connecting bar – implant supported or abutment supported	350	390
D6056	prefabricated abutment – includes modification and placement	135	290
D6057	custom fabricated abutment – includes placement	180	395
D6058	abutment supported porcelain/ceramic crown	320	710
D6059	abutment supported porcelain fused to metal crown (high noble metal)	315	710
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	295	575
D6061	abutment supported porcelain fused to metal crown (noble metal)	300	635
D6062	abutment supported cast metal crown (high noble metal)	315	675
D6063	abutment supported cast metal crown (predominantly base metal)	300	595
D6064	abutment supported cast metal crown (noble metal)	315	620
D6065	implant supported porcelain/ceramic crown	340	740
D6066	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	335	720
D6067	implant supported metal crown (titanium, titanium alloy, high noble metal)	340	730
D6068	abutment supported retainer for porcelain/ceramic FPD	320	680
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	315	705
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	290	630

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D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	300	680
D6072	abutment supported retainer for cast metal FPD (high noble metal)	315	690
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	290	630
D6074	abutment supported retainer for cast metal FPD (noble metal)	320	670
D6075	implant supported retainer for ceramic FPD	335	740
D6076	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	330	705
D6077	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	350	665
D6080	implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	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	30	
D6085	provisional implant crown	300	
D6090	repair implant supported prosthesis, by report	65	130
D6091	replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	40	200
D6092	re-cement or re-bond implant/abutment supported crown	25	60
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	35	80
D6094	abutment supported crown (titanium)	295	560
D6095	repair implant abutment, by report	65	150
D6096	remove broken implant retaining screw	65	
D6100	implant removal, by report	110	250
D6110	implant /abutment supported removable denture for edentulous arch – maxillary	350	925
D6111	implant /abutment supported removable denture for edentulous arch – mandibular	350	925
D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary	350	925
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular	350	925
D6114	implant /abutment supported fixed denture for edentulous arch – maxillary	350	925
D6115	implant /abutment supported fixed denture for edentulous arch – mandibular	350	925
D6116	implant /abutment supported fixed denture for partially edentulous arch – maxillary	350	925
D6117	implant /abutment supported fixed denture for partially edentulous arch – mandibular	350	925
D6190	radiographic/surgical implant index, by report	75	145
D6194	abutment supported retainer crown for FPD – (titanium)	265	575
D6199	unspecified implant procedure, by report	350	

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<b>IX. PROSTHODONTICS, FIXED</b>			
D6211	pontic – cast predominantly base metal	300	
D6241	pontic – porcelain fused to predominantly base metal	300	
D6245	pontic – porcelain/ceramic	300	350
D6251	pontic – resin with predominantly base metal	300	
D6721	retainer crown – resin with predominantly base metal	300	
D6740	retainer crown – porcelain/ceramic	300	380
D6751	retainer crown – porcelain fused to predominantly base metal	300	
D6781	retainer crown – ¾ cast predominantly base metal	300	330
D6783	retainer crown – ¾ porcelain/ceramic	300	350
D6791	retainer crown – full cast predominantly base metal	300	
D6930	re-cement or re-bond fixed partial denture	40	
D6980	fixed partial denture repair necessitated by restorative material failure	95	
D6999	unspecified fixed prosthodontic procedure, by report	350	
<b>X. ORAL &amp; MAXILLOFACIAL SURGERY</b>			
D7111	extraction, coronal remnants – primary tooth	40	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	65	
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	120	
D7220	removal of impacted tooth – soft tissue	95	
D7230	removal of impacted tooth – partially bony	145	
D7240	removal of impacted tooth – completely bony	160	
D7241	removal of impacted tooth – completely bony, with unusual surgical complications	175	
D7250	removal of residual tooth roots (cutting procedure)	80	
D7260	oroantral fistula closure	280	
D7261	primary closure of a sinus perforation	285	
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	185	
D7280	exposure of an unerupted tooth	220	
D7283	placement of device to facilitate eruption of impacted tooth	85	
D7285	incisional biopsy of oral tissue – hard (bone, tooth)	180	
D7286	incisional biopsy of oral tissue – soft	110	
D7290	surgical repositioning of teeth	185	



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D7291	transeptal fiberotomy/supra crestal fiberotomy, by report	80	
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	85	
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	50	
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	120	
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	65	
D7340	vestibuloplasty – ridge extension (secondary epithelialization)	350	
D7350	vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	350	
D7410	excision of benign lesion up to 1.25 cm	75	145
D7411	excision of benign lesion greater than 1.25 cm	115	300
D7412	excision of benign lesion, complicated	175	325
D7413	excision of malignant lesion up to 1.25 cm	95	
D7414	excision of malignant lesion greater than 1.25 cm	120	
D7415	excision of malignant lesion, complicated	255	
D7440	excision of malignant tumor – lesion diameter up to 1.25 cm	105	
D7441	excision of malignant tumor – lesion diameter greater than 1.25 cm	185	
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	180	
D7451	removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	330	
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	155	170
D7461	removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	250	
D7465	destruction of lesion(s) by physical or chemical method, by report	40	
D7471	removal of lateral exostosis (maxilla or mandible)	140	
D7472	removal of torus palatinus	145	
D7473	removal of torus mandibularis	140	
D7485	reduction of osseous tuberosity	105	
D7490	radical resection of maxilla or mandible	350	
D7510	incision and drainage of abscess – intraoral soft tissue	70	
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	70	
D7520	incision and drainage of abscess – extraoral soft tissue	70	400
D7521	incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	80	425
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	45	425
D7540	removal of reaction producing foreign bodies, musculoskeletal system	75	

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D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	125	
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	235	
<ul style="list-style-type: none"> <li>The following services are covered when preformed in a dental setting. If services are performed in a medical setting, services are covered under your medical coverage.</li> </ul>			
<b>Covered Only when Medically Necessary.</b>			
D7610	maxilla – open reduction (teeth immobilized, if present)	140	
D7620	maxilla – closed reduction (teeth immobilized, if present)	250	
D7630	mandible – open reduction (teeth immobilized, if present)	350	
D7640	mandible – closed reduction (teeth immobilized, if present)	350	
D7650	malar and/or zygomatic arch - open reduction	350	
D7660	malar and/or zygomatic arch – closed reduction	350	
D7670	alveolus – closed reduction, may include stabilization of teeth	170	
D7671	alveolus – open reduction, may include stabilization of teeth	230	
D7680	facial bones – complicated reduction with fixation and multiple surgical approaches	350	
D7710	maxilla – open reduction	110	
D7720	maxilla – closed reduction	180	
D7730	mandible – open reduction	350	
D7740	mandible – closed reduction	290	
D7750	malar and/or zygomatic arch – open reduction	220	
D7760	malar and/or zygomatic arch – closed reduction	350	
D7770	alveolus – open reduction stabilization of teeth	135	
D7771	alveolus, closed reduction stabilization of teeth	160	
D7780	facial bones – complicated reduction with fixation and multiple surgical approaches	350	
D7810	open reduction of dislocation	350	
D7820	closed reduction of dislocation	80	
D7830	manipulation under anesthesia	85	
D7840	condylectomy	350	
D7850	surgical discectomy, with/without implant	350	
D7852	disc repair	350	
D7854	synovectomy	350	
D7856	myotomy	350	
D7858	joint reconstruction	350	
D7860	arthrotomy	350	

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D7865	arthroplasty	350	
D7870	arthrocentesis	90	
D7871	non-arthroscopic lysis and lavage	150	
D7872	arthroscopy – diagnosis, with or without biopsy	350	
D7873	arthroscopy – surgical: lavage and lysis of adhesions	350	
D7874	arthroscopy – surgical: disc repositioning and stabilization	350	
D7875	arthroscopy – surgical: synovectomy	350	
D7876	arthroscopy – surgical: discectomy	350	
D7877	arthroscopy – surgical: debridement	350	
D7880	occlusal orthotic device, by report	120	
D7881	occlusal orthotic device adjustment	30	
D7899	unspecified TMD therapy, by report	350	
D7910	suture of recent small wounds up to 5 cm	35	
D7911	complicated suture – up to 5 cm	55	
D7912	complicated suture – greater than 5 cm	130	
D7920	skin graft (identify defect covered, location and type of graft)	120	
D7940	osteoplasty – for orthognathic deformities	160	
D7941	osteotomy – mandibular rami	350	
D7943	osteotomy – mandibular rami with bone graft; includes obtaining the graft	350	
D7944	osteotomy – segmented or subapical	275	
D7945	osteotomy – body of mandible	350	
D7946	LeFort I (maxilla – total)	350	
D7947	LeFort I (maxilla – segmented)	350	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	350	
D7949	LeFort II or LeFort III – with bone graft	350	
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	190	
D7951	sinus augmentation with bone or bone substitutes via a lateral open approach	290	
D7952	Sinus augmentation via a vertical approach	175	
D7955	repair of maxillofacial soft and/or hard tissue defect	200	
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	120	
D7963	frenuloplasty	120	
D7970	excision of hyperplastic tissue – per arch	175	

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D7971	excision of pericoronal gingiva	80	
D7972	surgical reduction of fibrous tuberosity	100	105
D7979	non-surgical sialolithotomy	155	
D7980	surgical sialolithotomy	155	
D7981	excision of salivary gland, by report	120	
D7982	sialodochoplasty	215	
D7983	closure of salivary fistula	140	
D7990	emergency tracheotomy	350	
D7991	coronoidectomy	345	
D7995	synthetic graft – mandible or facial bones, by report	150	
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	60	
D7999	unspecified oral surgery procedure, by report	350	
<b>XII. ADJUNCTIVE GENERAL SERVICES</b>			
D9110	palliative (emergency) treatment of dental pain – minor procedure	30	
D9120	fixed partial denture sectioning	95	
D9210	local anesthesia not in conjunction with operative or surgical procedures	10	
D9211	regional block anesthesia	20	
D9212	trigeminal division block anesthesia	60	
D9215	local anesthesia in conjunction with operative or surgical procedures	15	
D9222	deep sedation/general anesthesia – first 15 minutes	45	
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment	45	
D9230	inhalation of nitrous oxide/anoxiolysis, analgesia	15	
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	60	
D9243	intravenous moderate (conscious) sedation/anesthesia – each subsequent 15 minute increment	60	
D9248	non-intravenous conscious sedation	65	
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	50	
D9311	consultation with a medical health care professional	0	
D9410	house/extended care facility call	50	
D9420	hospital or ambulatory surgical center call	135	
D9430	office visit for observation (during regularly scheduled hours) – no other services performed	20	
D9440	office visit – after regularly scheduled hours	45	
D9610	therapeutic parenteral drug, single administration	30	

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D9612	therapeutic parenteral drugs, two or more administrations, different medications	40	
D9910	application of desensitizing medicament	20	
D9930	treatment of complications (post-surgical) – unusual circumstances, by report	35	
D9950	occlusion analysis – mounted case	120	
D9951	occlusal adjustment – limited	45	
D9952	occlusal adjustment – complete	210	
D9999	unspecified adjunctive procedure, by report	0	
<b>XI. ORTHODONTICS (ONLY MEDICALLY NECESSARY TREATMENT IS COVERED)</b>			
• Members Orthodontic Copayment is per phase of treatment and subject to plan frequencies, limitations and exclusions			
D8080	comprehensive orthodontic treatment of the adolescent dentition	2018 EHB 1,000	
D8210	removable appliance therapy		
D8220	fixed appliance therapy		
D8660	pre-orthodontic treatment examination to monitor growth and development		
D8670	periodic orthodontic treatment visit		
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))		
D8681	removable orthodontic retainer adjustment		
D8691	repair of orthodontic appliance	2019 EHB 350	
D8692	replacement of lost or broken retainer		
D8693	re-cement or re-bond fixed retainer		
D8694	repair of fixed retainers, includes reattachment		
D8999	unspecified orthodontic procedure, by report		

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

## LIMITATION OF BENEFITS

### DIAGNOSTIC AND PREVENTIVE SERVICES

1. Limited to once every 6 months (D0120, D0145, D0272, D0273, D0274, D0277, D1120, D1206, & D1208).
2. Limited to once per patient (D0140, D0150, D0160, & D0180).
3. Limited to 6 times in a 3 month period and to a maximum of 12 in a 12-month period (D0170 & D0171).
4. Limited to once every 36 months (D0210 & D0330).
5. Limited to a maximum of 20 periapicals in a 12-month period (D0220 & D0230).
6. Limited to twice in a 6 month period (D0240).
7. Limited to once per date of service (D0250, D0251 & D0270).
8. Limited to a maximum of 3 per date of service (D0320).
9. Limited to twice in a 12 month period (D0322 & D0340).
10. Limited to a maximum of 4 per date of service (D0350).
11. Limited to once per provider (D0470).
12. Limited to once in a 12-month period (D1110).
13. Covered in conjunction with your Periodic Oral Evaluation (D1310, D1320 & D1330).
14. Limited to once per tooth every 36 months regardless of surfaces sealed (D1351 & D1352).
15. Limited to 1 per quadrant per patient (D1510 & D1520).
16. Limited to once per quadrant per arch when there is a missing primary molar in both quadrants or when there are 2 missing primary molars in the same quadrant (D1516, D1517, D1526, & D1527).
17. Limited to once per applicable quadrant or arch (D1550).

### RESTORATIVE SERVICES

1.
  - Primary Teeth: Limited to once in a 12-month period (D2140 - D2161, D2330 - D2394, & D2932 - D2933).
  - Permanent Teeth: Limited to once in a 36-month period (D2140 - D2161, D2330 - D2394, & D2932 - D2933).
2. Limited to once per quadrant per patient (D1575).
3. Crowns are limited to once in a 5-year period (D2710 - D2791).
4. Limited to once in a 12-month period
5. Not covered if preformed within 12 months of a previous re-cementation by the same provider (D2915 & D2920).
6. Limited to once in a 36-month period (D2931).
7. Limited to once per tooth in a 6-month period (D2940).
8. Limited to once per tooth regardless of the number of pins placed (D2941, D2949, D2950, D2951, D2953, D2955, D2957 & D2971).
9. Limited to once per tooth regardless of number of posts placed

### ENDODONTIC SERVICES

1. Limited to once per primary tooth
2. Limited to once per tooth
3. Limited to once per permanent tooth (D3222, D3230, D3240, D3351 & D3352).
4. Limited to once per tooth for initial root canal therapy treatment
5. Not covered if performed within 12 months from initial treatment by the original provider (D3346 - D3348).
6. Not covered for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests (D3348, D3425, & D3426).
7. Not covered if performed within 90 days from root canal therapy unless medically necessary (D3410, D3421, D3425, & D3426).

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8. Not covered if preformed within 24 months of a prior apicoectomy/ periradicular surgery, same root (D3410, D3421, D3425 & D3426).
9. Limited to once per tooth for initial root canal therapy treatment (D3430, D3910, & D3999).

**PERIODONTAL SERVICES**

1. Limited to once per quadrant every 36 months (D4211 - D4265).
2. Limited to once per quadrant every 24 months (D4341, D4342, & D4346).
3. Limited to once per quadrant every 36 months (D4355).
4. Limited to once in a calendar quarter (D4910).
5. Limited to once per patient (D4920).

**PROSTHONTICS, REMOVABLE**

1. Limited to once in a 5 year period (D5110 - D5120, D5211 - D5214, D5221 - D5224, & D5862 - D5866).
2. Limited to once per patient (D5130 - D5140).
3. Limited to once per date of service (D5410 - D5422, D5511 - D5512,
4. Limited to twice in a 12-month period (D5410 - D5422, D5511 - D5512, D5611 - D5622, D5630, D5640,
5. Limited to a maximum of 4, per arch, per date of service (D5520 & D5640).
6. Limited to twice per arch, in a 12-month period (D5520, D5660).
7. Limited to a maximum of 3, per date of service (D5630, D5650, & D5660).
8. Limited to once per tooth (D5650).
9. Limited to once in a 12-month period (D5730 - D5761).
10. Limited to twice per prosthesis in a 36-month period (D5850 & D5851).

**IMPLANT SERVICES**

1. Not covered within the 12 months of previous recementation by the same provider (D6092 & D6093).
2. Limited to once in a 5-year period (D6199).

**PROSTHODONTICS, FIXED**

1. Limited to once in a 5-year period (D6211 - D6251, D6721 - D6791 & D6999).
2. Not covered within the 12 months of a previous recementation by the same provider (D6930).
3. Not covered within the 12 months of initial placement or previous repair, same provider (D6980).

**ORAL & MAXILLOFACIAL SURGERY**

1. Not covered if performed by the same provider who performed the initial tooth extraction (D7140 & D7250).
2. Not covered in conjunction with extraction procedures (D7260).
3. Covered when medically necessary and performed in a dental setting (D7261).
4. Limited to one per arch regardless of the number of teeth involved (D7270).
5. Not covered for 3rd molars (D7280).
6. Not covered for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position (D7283).
7. Limited to once per arch, per date of service regardless of the areas involved (D7285).
8. Limited to a maximum of 3 per date of service (D7286).
9. Limited to once per arch (D7290, D7291 & D7350).
10. Not covered when only one tooth is extracted in the same quadrant on the same date of service (D7310 & D7320).
11. Limited to once in a 5-year period per arch (D7340).

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12. Limited to once per quadrant (D7471, D7473, & D7485).
13. Limited to once per lifetime of patient (D7472).
14. Limited to once per quadrant, same date of service (D7510 - D7511, & D7972).
15. Limited to once per date of service (D7530 & D7540).
16. Limited to once per quadrant per date of service (D7550).
17. Limited to 1 per arch per visit (D7960, D7963, & D7970).

**ORTHODONTICS**

1. Limited to once per patient per phase of treatment (D8080).
2. Limited to once per patient (D8210 - D8220).
3. Limited to once every 3 months (D8660).
4. Limited to once per calendar quarter (D8670).
5. Limited to once per arch for each authorized phase of orthodontic treatment (D8680).
6. Limited to once per appliance (D8681, D8691 & D8694).
7. Limited to once per arch (D8692).
8. Limited to once per provider (D8693 & D8699).

**ADJUNCTIVE GENERAL SERVICES**

1. Limited to once per date of service (D9248).
2. Limited to once per date of service (D9430 & D9440).
3. Limited to a maximum of 4 injections per date of service (D9610).
4. Limited to once in a 12-month period (D9910 & D9950).
5. Limited to once per date of service (D9930).
6. Limited to once in a 12-month period per quadrant (D9951).
7. Limited to once in a 12-month period following occlusion analysis (D9952).

**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 Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
5. 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.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a participating dental setting. This will not apply to Covered Emergency Dental Services.
8. 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.
9. Placement of dental implants, implant-supported abutments and prostheses.



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10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
11. 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.
12. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
13. 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.
14. Replacement of complete dentures, fixed and removable partial dentures or crowns and, 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.
15. 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.
16. Expenses for Dental Procedures begun prior to the Member becoming enrolled under the Group Agreement.
17. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
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.

**ORTHODONTIC COVERAGE - MEDICALLY NECESSARY  
LIMITATION OF BENEFITS**

**Benefits for comprehensive orthodontic treatment coverage are approved by us, and are limited to the following instances related to an identifiable medical**

- Cleft lip and or palate
- Crouzon's syndrome

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- Treacher-Collins syndrome
- Pierre-Robin syndrome
- Hemi-facial atrophy
- Hem-facial hypertrophy
- Other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.

**EXCLUSION OF BENEFITS**

**Excluded from comprehensive orthodontic treatment coverage are the following conditions:**

- Crowded dentitions (crooked teeth)
- Excessive spacing between teeth
- Temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies
- Treatment in progress prior to the effective date of this coverage.
- Extractions required for orthodontic purposes
- Surgical orthodontics or jaw repositioning
- Myofunctional therapy
- Macroglossia
- Hormonal imbalances
- Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of accident
- Palatal expansion appliances
- Services performed by outside laboratories
- Replacement or repair of lost, stolen or broken appliances damaged due to the neglect of the Member

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

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			Member Copayment				
SPECIALTY REFERRAL BENEFITS (*\$1000 Calendar Year Maximum):			Ortho Only	YES*	YES	YES	YES
SUPPLEMENTAL REIMBURSEMENT:			NO	YES	YES	YES	YES
<b>I. DIAGNOSTIC</b>							
D0999	Office Visit - per visit		8	0	5	5	5
D0120	periodic oral evaluation – established patient		0	0	0	0	0
D0140	limited oral evaluation – problem focused		0	0	15	0	0
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver		0	0	0	0	0
D0150	comprehensive oral evaluation – new or established patient		0	0	0	0	0
D0160	detailed and extensive oral evaluation – problem focused, by report		0	0	0	0	0
D0170	re-evaluation – limited, problem focused (established patient; not post-operative		0	0	15	0	0
D0171	re-evaluation – post-operative office visit		8	0	0	0	0
D0180	comprehensive periodontal evaluation – new or established patient		0	0	0	0	0
D0190	screening of a patient		8	0	5	0	0
D0191	assessment of a patient		8	0	5	0	0
D0210	intraoral – complete series of radiographic images		0	0	5	0	0
D0220	intraoral – periapical first radiographic image		0	0	0	0	0
D0230	intraoral – periapical each additional radiographic image		0	0	0	0	0
D0240	intraoral – occlusal radiographic image		0	0	0	0	0
D0270	bitewing – single radiographic image		0	0	0	0	0
D0272	bitewings – two radiographic images		0	0	0	0	0
D0274	bitewings – four radiographic images		0	0	0	0	0
D0330	panoramic radiographic image		0	0	5	0	0
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report		NTCV	25	30	25	25
D0460	pulp vitality tests		0	0	0	0	0
D0470	diagnostic casts		10	10	20	15	15
D0502	other oral pathology procedures, by report		NTCV	0	NTCV	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
D0601	caries risk assessment and documentation, with a finding of low risk		0	0	0	0	0
D0602	caries risk assessment and documentation, with a finding of moderate risk		0	0	0	0	0
D0603	caries risk assessment and documentation, with a finding of high risk		0	0	0	0	0

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<b>II. PREVENTIVE</b>							
D1110	prophylaxis – adult		0	0	15	0	0
D1120	prophylaxis – child		0	0	10	0	0
D1208	topical application of fluoride – excluding varnish		0	0	3	0	0
D1310	nutritional counseling for control of dental disease		0	0	0	0	0
D1330	oral hygiene instructions		0	0	0	0	0
D1351	sealant – per tooth		NTCV	5	10	10	10
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent		NTCV	5	10	10	10
D1353	sealant repair – per tooth		NTCV	3	5	5	5
D1510	space maintainer – fixed, unilateral		NTCV	45	65	55	55
D1516	space maintainer – fixed – bilateral, maxillary		NTCV	45	65	55	55
D1517	space maintainer – fixed – bilateral, mandibular		NTCV	45	65	55	55
D1520	space maintainer – removable – unilateral		NTCV	45	65	55	55
D1526	space maintainer – removable – bilateral, maxillary		NTCV	45	65	55	55
D1527	space maintainer – removable – bilateral, mandibular		NTCV	45	65	55	55
D1550	re-cement or re-bond space maintainer		NTCV	10	NTCV	10	10
D1575	distal shoe space maintainer – fixed – unilateral		NTCV	45	65	55	55
<b>III. RESTORATIVE</b>							
* Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade. Members 16 years of age and older are limited to 7 crowns and/or pontics in any 12-month period and any single fixed bridge is limited to 4 units in length.							
† Higher copayments reflect molar tooth.							
D2140	amalgam – one surface, primary or permanent		22	4	19	7	7
D2150	amalgam – two surfaces, primary or permanent		28	5	23	10	10
D2160	amalgam – three surfaces, primary or permanent		38	6	27	15	15
D2161	amalgam – four or more surfaces, primary or permanent		48	8	31	20	20
D2330	resin-based composite – one surface, anterior		35	14	22	19	19
D2331	resin-based composite – two surfaces, anterior		35	14	26	19	19
D2332	resin-based composite – three surfaces, anterior		35	14	30	22	22
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		37	16	34	27	27
D2390	resin-based composite crown, anterior		NTCV	NTCV	40	40	40
D2391	resin-based composite – one surface, posterior		66	66	66	66	66
D2392	resin-based composite – two surfaces, posterior		85	85	85	85	85
D2393	resin-based composite – three surfaces, posterior		102	102	102	102	102
D2394	resin-based composite – four or more surfaces, posterior		117	117	117	117	117

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			Member Copayment				
D2410	gold foil – one surface		22	4	NTCV	NTCV	NTCV
D2420	gold foil – two surfaces		28	5	NTCV	NTCV	NTCV
D2430	gold foil – three surfaces		38	6	NTCV	NTCV	NTCV
D2510	inlay – metallic – one surface		NTCV	50*	200*	50*	50*
D2520	inlay – metallic – two surfaces		NTCV	70*	200*	70*	70*
D2530	inlay – metallic – three or more surfaces		NTCV	90*	200*	90*	90*
D2542	onlay – metallic – two surfaces		NTCV	110	200	110	110
D2543	onlay – metallic – three surfaces		NTCV	115	200	115	115
D2544	onlay – metallic – four or more surfaces		NTCV	120	200	120	120
D2710	crown – resin-based composite (indirect)	48	115	105	180	105	105
D2712	crown – ¼ resin-based composite (indirect)		115	105	180	105	105
D2720	crown – resin with high noble metal	48	154*	156*	250*	156*	156*
D2721	crown – resin with predominantly base metal	48	154	156	250	156	156
D2722	crown – resin with noble metal	48	154*	156*	250*	156*	156*
D2740	crown – porcelain/ceramic	48	187	120	250	175	175
D2750	crown – porcelain fused to high noble metal	48	220*	156*/236†	250*	175*/250†	175
D2751	crown – porcelain fused to predominantly base metal	48	220	156/236†	250	175/250†	175
D2752	crown – porcelain fused to noble metal	48	220	156*/236†	250*	175*/250†	175
D2780	crown – ¼ cast high noble metal	48	204*	120*	250*	175*	175*
D2781	crown – ¼ cast predominantly base metal	48	204	120	250	175	175
D2782	crown – ¼ cast noble metal	48	204*	120*	250*	175*	175*
D2783	crown – ¼ porcelain/ceramic	48	140	90	188	132	132
D2790	crown – full cast high noble metal	48	204*	142*	250*	175*	175*
D2791	crown – full cast predominantly base metal	48	204	142	250	175	175
D2792	crown – full cast noble metal	48	204*	142*	250*	175*	175*
D2794	crown – titanium	48	204*	142*	250*	175*	175*
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		NTCV	10	10	10	10
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		12	10	10	10	10
D2920	re-cement or re-bond crown		12	10	10	10	10
D2921	reattachment of tooth fragment, incisal edge or cusp		18	7	11	10	10
D2929	prefabricated porcelain/ceramic crown – primary tooth		55	17	25	25	25
D2930	prefabricated stainless steel crown – primary tooth		45	17	25	25	25
D2931	prefabricated stainless steel crown – permanent tooth		55	17	25	25	25
D2932	prefabricated resin crown		55	17	25	25	25

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			Member Copayment				
D2940	protective restoration		7	5	10	5	5
D2941	interim therapeutic restoration – primary dentition		6	4	8	4	4
D2949	restorative foundation for an indirect restoration		35	14	22	19	19
D2950	core buildup, including any pins when required		0	0	50	15	15
D2951	pin retention – per tooth, in addition to restoration		20	5	20	15	15
D2952	post and core in addition to crown, indirectly fabricated		75*	65*	90*	75*	75*
D2953	each additional indirectly fabricated post – same tooth		60*	52*	72*	60*	60*
D2954	prefabricated post and core in addition to crown		77	35	50	45	45
D2957	each additional prefabricated post – same tooth		62	28	40	36	36
D2971	additional procedures to construct new crown under existing partial denture		100	100	100	100	100
D2975	coping		102	71	125	88	88
D2990	resin infiltration of incipient smooth surface lesions		NTCV	5	10	10	10
<b>IV. ENDODONTICS</b>							
D3110	pulp cap – direct (excluding final restoration)		17	5	10	5	5
D3120	pulp cap – indirect (excluding final restoration)		17	12	12	12	12
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament		28	12	15	12	12
D3221	pulpal debridement, primary and permanent teeth		28	12	15	12	12
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development		NTCV	0	0	0	0
D3310	endodontic therapy, anterior tooth (excluding final restoration)		138	80	110	100	100
D3320	endodontic therapy, premolar tooth (excluding final restoration)		165	100	130	120	120
D3330	endodontic therapy, molar tooth (excluding final restoration)		204	140	200	180	180
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		102	70	100	90	90
D3346	retreatment of previous root canal therapy – anterior		NTCV	80	120	110	110
D3347	retreatment of previous root canal therapy – premolar		NTCV	100	140	130	130
D3348	retreatment of previous root canal therapy – molar		NTCV	140	210	200	200
D3410	apicoectomy – anterior		NTCV	NTCV	NTCV	NTCV	NTCV
D3421	apicoectomy – premolar (first root)		NTCV	NTCV	NTCV	NTCV	NTCV
D3425	apicoectomy – molar (first root)		NTCV	NTCV	NTCV	NTCV	NTCV
D3426	apicoectomy – (each additional root)		NTCV	NTCV	NTCV	NTCV	NTCV
D3427	periradicular surgery without apicoectomy		NTCV	NTCV	NTCV	NTCV	NTCV
D3430	retrograde filling – per root		NTCV	0	NTCV	NTCV	NTCV

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			Member Copayment				
D3910	surgical procedure for isolation of tooth with rubber dam		NTCV	0	0	0	0
D3950	canal preparation and fitting of preformed dowel or post		77	0	0	0	0
<b>V. PERIODONTICS</b>							
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant		165	100	120	120	120
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant		20	15	35	20	20
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth		7	5	12	7	7
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant		150	150	210	200	200
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant		75	75	105	100	100
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant		NTCV	200	310	290	290
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant		NTCV	100	155	145	145
D4341	periodontal scaling and root planing – four or more teeth per quadrant		40	40	50	50	50
D4342	periodontal scaling and root planing – one to three teeth per quadrant		20	20	25	25	25
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation			12	20	12	12
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit		40	40	50	50	50
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth		NTCV	NTCV	35	35	35
D4910	periodontal maintenance		25	15	25	15	15
D4920	unscheduled dressing change (by someone other than treating dentist or their		0	0	0	0	0
D4921	gingival irrigation - per quadrant		0	0	3	0	0
<b>VI. PROSTHODONTICS, REMOVABLE</b>							
<b>*Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade.</b>							
D5110	complete denture – maxillary	108	308	160	300	195	195
D5120	complete denture – mandibular	108	308	160	300	195	195
D5130	immediate denture – maxillary	108	308	160	300	195	195
D5140	immediate denture – mandibular	108	308	160	300	195	195

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			Member Copayment				
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	108	275	150	300	180	180
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	108	275	150	300	180	180
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	108	308*	175*	300*	210*	210*
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	108	308*	175*	300*	210*	210*
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		NTCV	0	NTCV	30	30
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		NTCV	0	NTCV	30	30
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		NTCV	0*	NTCV	38	38
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		NTCV	0*	NTCV	38	38
D5225	maxillary partial denture – flexible base (including any clasps, rests and teeth)	108	275	150	300	180	180
D5226	mandibular partial denture – flexible base (including any clasps, rests and teeth)	108	275	150	300	180	180
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary		308*	175*	NTCV	195*	195*
D5283	removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular		308*	175*	NTCV	195*	195*
D5410	adjust complete denture – maxillary		22	0	0	0	0
D5411	adjust complete denture – mandibular		22	0	0	0	0
D5421	adjust partial denture – maxillary		22	0	0	0	0
D5422	adjust partial denture – mandibular		22	0	0	0	0
D5511	repair broken complete denture base, mandibular		41	15	30	25	25
D5512	repair broken complete denture base, maxillary		41	15	30	25	25
D5520	replace missing or broken teeth – complete denture (each tooth)		28*	18*	30*	25*	25*
D5611	repair resin partial denture base, mandibular		41	15	30	25	25
D5612	repair resin partial denture base, maxillary		41	15	30	25	25
D5621	repair cast partial framework, mandibular		41	15	30	25	25
D5622	repair cast partial framework, maxillary		41	15	30	25	25
D5630	repair or replace broken clasp – per tooth		28	18	30	25	25



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D5640	replace broken teeth – per tooth		28*	18*	30*	25*	25*
D5650	add tooth to existing partial denture		44*	18*	30*	20*	20*
D5660	add clasp to existing partial denture – per tooth		44	18	30	20	20
D5670	replace all teeth and acrylic on cast metal framework (maxillary)		154*	88*	150*	105*	105*
D5671	replace all teeth and acrylic on cast metal framework (mandibular)		154*	88*	150*	105*	105*
D5730	reline complete maxillary denture (chairside)		50	20	40	30	30
D5731	reline complete mandibular denture (chairside)		50	20	40	30	30
D5740	reline maxillary partial denture (chairside)		50	20	40	30	30
D5741	reline mandibular partial denture (chairside)		50	20	40	30	30
D5750	reline complete maxillary denture (laboratory)		87	42	65	65	65
D5751	reline complete mandibular denture (laboratory)		87	42	65	65	65
D5760	reline maxillary partial denture (laboratory)		87	42	65	65	65
D5761	reline mandibular partial denture (laboratory)		87	42	65	65	65
D5820	interim partial denture (maxillary)		NTCV	0	NTCV	30	30
D5821	interim partial denture (mandibular)		NTCV	0	NTCV	30	30
D5863	overdenture - complete maxillary		308	268	408	303	303
D5864	overdenture - complete mandibular		308	268	408	303	303
D5865	overdenture - partial maxillary		308	283	408	318	318
D5866	overdenture - partial mandibular		308	283	408	318	318

**VII. PROSTHODONTICS, FIXED**

\*Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade. Members 16 years of age and older are limited to 7 crowns and/or pontics in any 12-month period and any single fixed bridge is limited to 4 units in length.

D6210	pontic – cast high noble metal	48	175*	142*	250*	175*	175*
D6211	pontic – cast predominantly base metal	48	175	142	250	175	175
D6212	pontic – cast noble metal	48	175*	142*	250*	175*	175*
D6214	pontic – titanium		175*	142*	250*	175*	175*
D6240	pontic – porcelain fused to high noble metal	48	200*	156*	250*	175*	175*
D6241	pontic – porcelain fused to predominantly base metal	48	200	156	250	175	175
D6242	pontic – porcelain fused to noble metal	48	200*	156*	250*	175*	175*
D6245	pontic – porcelain/ceramic	48	200	156	250	175	175
D6250	pontic – resin with high noble metal	48	155*	156*	250*	175*	175*
D6251	pontic – resin with predominantly base metal	48	155	156	250	175	175
D6252	pontic – resin with noble metal	48	155*	156*	250*	175*	175*
D6602	retainer inlay – cast high noble metal, two surfaces		NTCV	70*	200*	70*	70*



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			Member Copayment				
D6603	retainer inlay – cast high noble metal, three or more surfaces		NTCV	90*	200*	90*	90*
D6604	retainer inlay – cast predominantly base metal, two surfaces		NTCV	70	200	70	70
D6605	retainer inlay – cast predominantly base metal, three or more surfaces		NTCV	90	200	90	90
D6606	retainer inlay – cast noble metal, two surfaces		NTCV	70*	200*	70*	70*
D6607	retainer inlay – cast noble metal, three or more surfaces		NTCV	90*	200*	90*	90*
D6610	retainer onlay – cast high noble metal, two surfaces		NTCV	110*	200*	110*	110*
D6611	retainer onlay – cast high noble metal, three or more surfaces		NTCV	115*	200*	115*	115*
D6612	retainer onlay – cast predominantly base metal, two surfaces		NTCV	110	200	110	110
D6613	retainer onlay – cast predominantly base metal, three or more surfaces		NTCV	115	200	115	115
D6614	retainer onlay – cast noble metal, two surfaces		NTCV	110*	200*	110*	110*
D6615	retainer onlay – cast noble metal, three or more surfaces		NTCV	115*	200*	115*	115*
D6624	retainer inlay – titanium		NTCV	90*	200*	90*	90*
D6634	retainer onlay – titanium		NTCV	115*	200*	115*	115*
D6720	retainer crown – resin with high noble metal	48	154*	156*	250*	156*	156*
D6721	retainer crown – resin with predominantly base metal	48	154	156	250	NTCV	NTCV
D6722	retainer crown – resin with noble metal	48	154*	156*	250*	156*	156*
D6740	retainer crown – porcelain/ceramic	48	187	120	250	175	175
D6750	retainer crown – porcelain fused to high noble metal	48	220*	156*	250*	175*	175*
D6751	retainer crown – porcelain fused to predominantly base metal	48	220	156	250	175	175
D6752	retainer crown – porcelain fused to noble metal	48	220*	156*	250*	175*	175*
D6780	retainer crown – ¾ cast high noble metal	48	204*	120*	250*	175*	175*
D6781	retainer crown – ¾ cast predominantly base metal	48	204	120	250	175	175
D6782	retainer crown – ¾ cast noble metal	48	204*	120*	250*	175*	175*
D6783	retainer crown – ¾ porcelain/ceramic	48	204	120	250	175	175
D6790	retainer crown – full cast high noble metal	48	204*	142*	250*	175*	175*
D6791	retainer crown – full cast predominantly base metal	48	204	142	250	175	175
D6792	retainer crown – full cast noble metal	48	204*	142*	250*	175*	175*
D6794	retainer crown – titanium	48	204*	142*	250*	175*	175*
D6930	re-cement or re-bond fixed partial denture		25	12	10	0	0
<b>VIII. ORAL &amp; MAXILLOFACIAL SURGERY</b>							
D7111	extraction, coronal remnants – primary tooth		21	8	15	8	8
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)		21	10	15	10	10

EXHIBIT 2 - PART V

CDT Code	Plan Name Copayment Schedule Agreement ID:	Supplemental Payment	DENTAL 100	DENTAL 132	DENTAL 140	DENTAL 142	DENTAL 142 FEDS
			SFSGD0000008	SFSGD0000013	SFSGD0000014	SFSGD0000007	SFSGD0000016
			Member Copayment				
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		45	30	35	30	30
D7220	removal of impacted tooth – soft tissue		65	40	60	50	50
D7230	removal of impacted tooth – partially bony		NTCV	50	70	60	60
D7240	removal of impacted tooth – completely bony		NTCV	75	90	90	90
D7241	removal of impacted tooth – completely bony, with unusual surgical complications		NTCV	75	90	90	90
D7250	removal of residual tooth roots (cutting procedure)		45	30	60	50	50
D7285	incisional biopsy of oral tissue – hard (bone, tooth)		NTCV	10	30	20	20
D7286	incisional biopsy of oral tissue – soft		NTCV	6	20	10	10
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		NTCV	70	60	70	70
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		NTCV	53	45	53	53
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		NTCV	80	80	80	80
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		NTCV	60	60	60	60
D7471	removal of lateral exostosis (maxilla or mandible)		NTCV	100	100	100	100
D7472	removal of torus palatinus		NTCV	100	100	100	100
D7473	removal of torus mandibularis		NTCV	100	100	100	100
D7485	reduction of osseous tuberosity		NTCV	100	100	100	100
D7510	incision and drainage of abscess – intraoral soft tissue		40	14	40	20	20
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		60	21	60	30	30
D7520	incision and drainage of abscess – extraoral soft tissue		40	14	NTCV	NTCV	NTCV
D7521	incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		60	21	NTCV	NTCV	NTCV
D7881	occlusal orthotic device adjustment		22	0	0	0	0
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure		NTCV	25	40	30	30
D7972	surgical reduction of fibrous tuberosity		NTCV	100	100	100	100
<b>IX. ADJUNCTIVE GENERAL SERVICES</b>							
D9110	palliative (emergency) treatment of dental pain – minor procedure		20	5	10	5	5
D9211	regional block anesthesia		0	0	0	0	0

**UNITEDHEALTHCARE / PACIFICARE DHMO**  
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			SFSGD0000008	SFSGD0000013	SFSGD0000014	SFSGD0000007	SFSGD0000016
			Member Copayment				
D9212	trigeminal division block anesthesia		0	0	0	0	0
D9215	local anesthesia in conjunction with operative or surgical procedures		0	0	0	0	0
D9219	evaluation for deep sedation or general anesthesia		NTCV	25	30	25	25
D9222	deep sedation/general anesthesia – first 15 minutes		150	150	150	150	150
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment		45	45	45	45	45
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes		175	175	175	175	175
D9243	intravenous moderate (conscious) sedation/anesthesia – each subsequent 15 minute increment		53	53	53	53	53
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		NTCV	25	30	25	25
D9311	consultation with a medical health care professional		8	0	0	0	0
D9430	office visit for observation (during regularly scheduled hours) – no other services performed		8	0	5	0	0
D9440	office visit – after regularly scheduled hours		25	10	NTCV	20	20
D9450	case presentation, detailed and extensive treatment planning		0	0	0	0	0
D9930	treatment of complications (post-surgical) – unusual circumstances, by report		0	0	0	0	0
D9943	occlusal guard adjustment		22	0	0	0	0
D9951	occlusal adjustment – limited		0	0	20	0	0
D9952	occlusal adjustment – complete		NTCV	0	NTCV	0	0
	Broken Appointment, with no prior notification at least 24 hrs before the scheduled appointment		20	20	20	20	20

**FOOTNOTE:** Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade. Members 16 years of age and older are limited to 7 crowns and/or pontics in any 12-month period and any single fixed bridge is limited to 4 units in length. *The supplemental reimbursement is in addition to this amount.*

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

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CDT Code	Plan Name Copayment Schedule Agreement ID:	Supplemental Payment	DENTAL 144	DENTAL 146	DENTAL 160	DENTAL 161	590H
			SFSGD0000003	SFSGD0000018	SFSGD0000019	SFSGD0000020	SFSGD0000015
			<b>Member Copayment</b>				
<b>SPECIALTY REFERRAL BENEFITS (*\$1000 Calendar Year Maximum):</b>			YES	YES	Ortho Only	YES*	YES*
<b>SUPPLEMENTAL REIMBURSEMENT APPLIES:</b>			YES	YES	NO	NO	NO
<b>I. DIAGNOSTIC</b>							
D0999	Office Visit - per visit		5	0	0	0	0
D0120	periodic oral evaluation – established patient		0	0	0	0	0
D0140	limited oral evaluation – problem focused		0	0	5	5	0
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver		0	0	0	0	0
D0150	comprehensive oral evaluation – new or established patient		0	0	0	0	0
D0160	detailed and extensive oral evaluation – problem focused, by report		0	0	0	0	0
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)		0	0	5	5	0
D0171	re-evaluation – post-operative office visit		0	0	0	0	5
D0180	comprehensive periodontal evaluation – new or established patient		0	0	0	0	0
D0190	screening of a patient		0	0	0	0	5
D0191	assessment of a patient		0	0	0	0	5
D0210	intraoral – complete series of radiographic images		0	0	0	0	0
D0220	intraoral – periapical first radiographic image		0	0	0	0	0
D0230	intraoral – periapical each additional radiographic image		0	0	0	0	0
D0240	intraoral – occlusal radiographic image		0	0	0	0	0
D0270	bitewing – single radiographic image		0	0	0	0	0
D0272	bitewings – two radiographic images		0	0	0	0	0
D0274	bitewings – four radiographic images		0	0	0	0	0
D0330	panoramic radiographic image		0	0	0	0	0
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report		15	10	NTCV	25	25
D0460	pulp vitality tests		0	0	0	0	0
D0470	diagnostic casts		10	7	10	10	10
D0502	other oral pathology procedures, by report		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
D0601	caries risk assessment and documentation, with a finding of low risk		0	0	0	0	0
D0602	caries risk assessment and documentation, with a finding of moderate risk		0	0	0	0	0
D0603	caries risk assessment and documentation, with a finding of high risk		0	0	0	0	0

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			<b>Member Copayment</b>				
<b>II. PREVENTIVE</b>							
D1110	prophylaxis – adult		0	0	0	0	0
D1120	prophylaxis – child		0	0	0	0	NTCV
D1208	topical application of fluoride – excluding varnish		0	0	0	0	NTCV
D1310	nutritional counseling for control of dental disease		0	0	0	0	NTCV
D1330	oral hygiene instructions		0	0	0	0	0
D1351	sealant – per tooth		7	7	NTCV	NTCV	NTCV
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth		7	7	NTCV	NTCV	NTCV
D1353	sealant repair – per tooth		4	4	NTCV	NTCV	NTCV
D1510	space maintainer – fixed, unilateral		35	20	55	55	45
D1516	space maintainer – fixed – bilateral, maxillary		35	20	55	55	45
D1517	space maintainer – fixed – bilateral, mandibular		35	20	55	55	45
D1520	space maintainer – removable – unilateral		35	20	55	55	45
D1526	space maintainer – removable – bilateral, maxillary		35	20	55	55	45
D1527	space maintainer – removable – bilateral, mandibular		35	20	55	55	45
D1550	re-cement or re-bond space maintainer		0	0	0	0	10
D1575	distal shoe space maintainer – fixed – unilateral		35	20	55	55	45
<b>III. RESTORATIVE</b>							
* Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade. Members 16 years of age and older are limited to 7 crowns and/or pontics in any							
† Higher copayments reflect molar tooth.							
D2140	amalgam – one surface, primary or permanent		4	0	15	15	4
D2150	amalgam – two surfaces, primary or permanent		5	0	20	20	5
D2160	amalgam – three surfaces, primary or permanent		6	0	26	26	6
D2161	amalgam – four or more surfaces, primary or permanent		10	0	34	34	8
D2330	resin-based composite – one surface, anterior		15	15	25	25	14
D2331	resin-based composite – two surfaces, anterior		15	15	25	25	14
D2332	resin-based composite – three surfaces, anterior		17	17	25	25	14
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		20	20	28	28	16
D2390	resin-based composite crown, anterior		40	40	NTCV	NTCV	NTCV
D2391	resin-based composite – one surface, posterior		66	66	66	66	66
D2392	resin-based composite – two surfaces, posterior		85	85	85	85	85
D2393	resin-based composite – three surfaces, posterior		102	102	102	102	102

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			Member Copayment				
D2394	resin-based composite – four or more surfaces, posterior		117	117	117	117	117
D2410	gold foil – one surface		NTCV	NTCV	15	15	4
D2420	gold foil – two surfaces		NTCV	NTCV	20	20	5
D2430	gold foil – three surfaces		NTCV	NTCV	26	26	6
D2510	inlay – metallic – one surface		25*	25*	75*	75*	50*
D2520	inlay – metallic – two surfaces		30*	30*	90*	90*	70*
D2530	inlay – metallic – three or more surfaces		35*	35*	105*	105*	90*
D2542	onlay – metallic – two surfaces		45	45	120	120	110
D2543	onlay – metallic – three surfaces		50	50	130	130	115
D2544	onlay – metallic – four or more surfaces		55	55	140	140	120
D2710	crown – resin-based composite (indirect)	48	105	90	85	85	105
D2712	crown – ¾ resin-based composite (indirect)		105	90	85	85	105
D2720	crown – resin with high noble metal	48	105*	90*	110*	110*	124*
D2721	crown – resin with predominantly base metal	48	105	90	110	110	124
D2722	crown – resin with noble metal	48	105*	90*	110*	110*	124*
D2740	crown – porcelain/ceramic	48	125	110	130	130	120
D2750	crown – porcelain fused to high noble metal	48	125*/200†	110*/190†	165*/245†	165*/245†	156*
D2751	crown – porcelain fused to predominantly base metal	48	125/200†	110/190†	165/245†	165/245†	156
D2752	crown – porcelain fused to noble metal	48	125*/200†	110*/190†	165*/245†	165*/245†	156*
D2780	crown – ¾ cast high noble metal	48	125*	110*	140*	140*	120*
D2781	crown – ¾ cast predominantly base metal	48	125	110	140	140	120
D2782	crown – ¾ cast noble metal	48	125*	110*	140*	140*	120*
D2783	crown – ¾ porcelain/ceramic	48	94	83	98	98	90
D2790	crown – full cast high noble metal	48	125*	110*	145*	145*	142*
D2791	crown – full cast predominantly base metal	48	125	110	145	145	142
D2792	crown – full cast noble metal	48	125*	110*	145*	145*	142*
D2794	crown – titanium	48	125*	110*	145*	145*	142*
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		0	0	12	12	10
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		0	0	12	12	10
D2920	re-cement or re-bond crown		0	0	12	12	10
D2921	reattachment of tooth fragment, incisal edge or cusp		8	8	13	13	7
D2929	prefabricated porcelain/ceramic crown – primary tooth		15	10	45	45	17
D2930	prefabricated stainless steel crown – primary tooth		15	10	30	30	NTCV
D2931	prefabricated stainless steel crown – permanent tooth		15	10	45	45	17
D2932	prefabricated resin crown		15	10	45	45	17

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			Member Copayment				
D2940	protective restoration		5	0	7	7	5
D2941	interim therapeutic restoration – primary dentition		4	0	6	6	4
D2949	restorative foundation for an indirect restoration		15	15	25	25	14
D2950	core buildup, including any pins when required		10	5	0	0	0
D2951	pin retention – per tooth, in addition to restoration		10	5	5	5	5
D2952	post and core in addition to crown, indirectly fabricated		60*	60*	65*	65*	65*
D2953	each additional indirectly fabricated post – same tooth		48*	48*	52*	52*	52*
D2954	prefabricated post and core in addition to crown		40	35	50	50	35
D2957	each additional prefabricated post – same tooth		32	28	40	40	28
D2971	additional procedures to construct new crown under existing partial denture framework		100	100	100	100	100
D2975	coping		63	55	73	73	71
D2990	resin infiltration of incipient smooth surface lesions		7	7	NTCV	NTCV	NTCV
<b>IV. ENDODONTICS</b>							
D3110	pulp cap – direct (excluding final restoration)		5	0	10	10	5
D3120	pulp cap – indirect (excluding final restoration)		5	0	24	24	5
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament		5	0	22	22	12
D3221	pulpal debridement, primary and permanent teeth		5	0	22	22	12
D3222	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development		0	0	0	NTCV	NTCV
D3310	endodontic therapy, anterior tooth (excluding final restoration)		60	45	100	100	80
D3320	endodontic therapy, premolar tooth (excluding final restoration)		105	85	130	130	100
D3330	endodontic therapy, molar tooth (excluding final restoration)		150	130	175	175	140
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		75	65	88	88	70
D3346	retreatment of previous root canal therapy – anterior		70	55	100	100	80
D3347	retreatment of previous root canal therapy – premolar		110	95	130	130	100
D3348	retreatment of previous root canal therapy – molar		170	145	175	175	140
D3410	apicoectomy – anterior		70	55	NTCV	100	NTCV
D3421	apicoectomy – premolar (first root)		70	55	NTCV	100	NTCV
D3425	apicoectomy – molar (first root)		70	55	NTCV	100	NTCV
D3426	apicoectomy – (each additional root)		70	55	NTCV	100	NTCV
D3427	periradicular surgery without apicoectomy		70	55	NTCV	100	NTCV
D3430	retrograde filling – per root		0	0	0	0	0



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			Member Copayment				
D3910	surgical procedure for isolation of tooth with rubber dam		0	0	NTCV	NTCV	NTCV
D3950	canal preparation and fitting of preformed dowel or post		0	0	0	0	0
<b>V. PERIODONTICS</b>							
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant		70	40	115	115	100
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant		10	5	20	20	30
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth		3	2	7	7	10
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant		190	180	200	200	150
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant		95	90	100	100	75
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant		250	230	NTCV	200	300
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant		125	115	NTCV	100	150
D4341	periodontal scaling and root planing – four or more teeth per quadrant		45	40	40	40	40
D4342	periodontal scaling and root planing – one to three teeth per quadrant		23	20	20	20	20
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		0	0	16	16	20
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit		45	40	40	40	40
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth		30	25	NTCV	NTCV	NTCV
D4910	periodontal maintenance		0	0	20	20	25
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)		0	0	0	0	0
D4921	gingival irrigation - per quadrant		0	0	0	0	NTCV
<b>VI. PROSTHODONTICS, REMOVABLE</b>							
*Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade.							
D5110	complete denture – maxillary	108	125	110	250	250	160
D5120	complete denture – mandibular	108	125	110	250	250	160
D5130	immediate denture – maxillary	108	125	110	250	250	160
D5140	immediate denture – mandibular	108	125	110	250	250	160

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			Member Copayment				
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	108	100	90	225	225	150
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	108	100	90	225	225	150
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	108	130*	125*	255*	255	175*
D5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	108	130*	125*	255*	255	175*
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)		20	10	60	60	0
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)		20	10	60	60	0
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		25	13	75	75	0
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		25	13	75	75	0
D5225	maxillary partial denture – flexible base (including any clasps, rests and teeth)	108	100	90	225	225	150
D5226	mandibular partial denture – flexible base (including any clasps, rests and teeth)	108	100	90	225	225	150
D5282	removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary		120*	100*	255*	255*	175*
D5283	removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular		120*	100*	255*	255*	175*
D5410	adjust complete denture – maxillary		0	0	12	12	0
D5411	adjust complete denture – mandibular		0	0	12	12	0
D5421	adjust partial denture – maxillary		0	0	12	12	0
D5422	adjust partial denture – mandibular		0	0	12	12	0
D5511	repair broken complete denture base, mandibular		15	10	28	28	15
D5512	repair broken complete denture base, maxillary		15	10	28	28	15
D5520	replace missing or broken teeth – complete denture (each tooth)		15*	10*	23*	23*	18*
D5611	repair resin partial denture base, mandibular		15	10	28	28	15
D5612	repair resin partial denture base, maxillary		15	10	28	28	15
D5621	repair cast partial framework, mandibular		15	10	28	28	15
D5622	repair cast partial framework, maxillary		15	10	28	28	15
D5630	repair or replace broken clasp – per tooth		15	10	31	31	18
D5640	replace broken teeth – per tooth		15*	10*	31*	31*	18*

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			Member Copayment				
D5650	add tooth to existing partial denture		10*	10*	31*	31*	18*
D5660	add clasp to existing partial denture – per tooth		10	10	31	31	18
D5670	replace all teeth and acrylic on cast metal framework (maxillary)		65*	63*	128*	128*	88*
D5671	replace all teeth and acrylic on cast metal framework (mandibular)		65*	63*	128*	128*	88*
D5730	reline complete maxillary denture (chairside)		15	10	35	35	20
D5731	reline complete mandibular denture (chairside)		15	10	35	35	20
D5740	reline maxillary partial denture (chairside)		15	10	35	35	20
D5741	reline mandibular partial denture (chairside)		15	10	35	35	20
D5750	reline complete maxillary denture (laboratory)		60	50	65	65	42
D5751	reline complete mandibular denture (laboratory)		60	50	65	65	42
D5760	reline maxillary partial denture (laboratory)		60	50	65	65	42
D5761	reline mandibular partial denture (laboratory)		60	50	65	65	42
D5820	interim partial denture (maxillary)		20	10	60	60	0
D5821	interim partial denture (mandibular)		20	10	60	60	0
D5863	overdenture - complete maxillary		233	218	250	250	268
D5864	overdenture - complete mandibular		233	218	250	250	268
D5865	overdenture - partial maxillary		238	233	255	255	283
D5866	overdenture - partial mandibular		238	233	255	255	283
<b>IX. PROSTHODONTICS, FIXED</b>							
*Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade. Members 16 years of age and older are limited to 7 crowns and/or pontics in any 12-month period and any single fixed bridge is limited to 4 units in length.							
D6210	pontic – cast high noble metal	48	125*	110*	145*	145*	142*
D6211	pontic – cast predominantly base metal	48	125	110	145	145	142
D6212	pontic – cast noble metal	48	125*	110*	145*	145*	142*
D6214	pontic – titanium		125*	110*	145*	145*	142*
D6240	pontic – porcelain fused to high noble metal	48	125*	110*	165*	165*	156*
D6241	pontic – porcelain fused to predominantly base metal	48	125	110	165	165	156
D6242	pontic – porcelain fused to noble metal	48	125*	110*	165*	165*	156*
D6245	pontic – porcelain/ceramic	48	125	110	165	165	156
D6250	pontic – resin with high noble metal	48	125*	110*	125*	125*	124*
D6251	pontic – resin with predominantly base metal	48	125	110	125	125	124
D6252	pontic – resin with noble metal	48	125*	110*	125*	125*	124*
D6602	retainer inlay – cast high noble metal, two surfaces		30*	30*	90*	90*	70*
D6603	retainer inlay – cast high noble metal, three or more surfaces		35*	35*	105*	105*	90*

**EXHIBIT 2 - PART VI**

CDT Code	Plan Name Copayment Schedule Agreement ID:	Supplemental Payment	DENTAL 144	DENTAL 146	DENTAL 160	DENTAL 161	590H
			SFSGD0000003	SFSGD0000018	SFSGD0000019	SFSGD0000020	SFSGD0000015
			Member Copayment				
D6604	retainer inlay – cast predominantly base metal, two surfaces		30	30	90	90	70
D6605	retainer inlay – cast predominantly base metal, three or more surfaces		35	35	105	105	90
D6606	retainer inlay – cast noble metal, two surfaces		30*	30*	90*	90*	70*
D6607	retainer inlay – cast noble metal, three or more surfaces		35*	35*	105*	105*	90*
D6610	retainer onlay – cast high noble metal, two surfaces		45*	45*	120*	120*	45*
D6611	retainer onlay – cast high noble metal, three or more surfaces		50*	50*	130*	130*	50*
D6612	retainer onlay – cast predominantly base metal, two surfaces		45	45	120	120	45
D6613	retainer onlay – cast predominantly base metal, three or more surfaces		50	50	130	130	50
D6614	retainer onlay – cast noble metal, two surfaces		45*	45*	120*	120*	110*
D6615	retainer onlay – cast noble metal, three or more surfaces		50*	50*	130*	130*	50*
D6624	retainer inlay – titanium		35*	35*	105*	105*	90*
D6634	retainer onlay – titanium		50*	50*	130*	130*	115*
D6720	retainer crown – resin with high noble metal	48	105*	90*	110*	110*	124*
D6722	retainer crown – resin with noble metal	48	105*	90*	110*	110*	124*
D6740	retainer crown – porcelain/ceramic	48	125	110	130	130	120
D6750	retainer crown – porcelain fused to high noble metal	48	125*	110*	165*	165*	156*
D6751	retainer crown – porcelain fused to predominantly base metal	48	125	110	165	165	156
D6752	retainer crown – porcelain fused to noble metal	48	125*	110*	165*	165*	156*
D6780	retainer crown – ¾ cast high noble metal	48	125*	110*	140*	140*	120*
D6781	retainer crown – ¾ cast predominantly base metal	48	125	110	140	140	120
D6782	retainer crown – ¾ cast noble metal	48	125*	110*	140*	140*	120*
D6783	retainer crown – ¾ porcelain/ceramic	48	125	110	140	140	120
D6790	retainer crown – full cast high noble metal	48	125*	110*	145*	145*	142*
D6791	retainer crown – full cast predominantly base metal	48	125	110	145	145	142
D6792	retainer crown – full cast noble metal	48	125*	110*	145*	145*	142*
D6794	retainer crown – titanium	48	125*	110*	145*	145*	NTCV
D6930	re-cement or re-bond fixed partial denture		0	0	18	18	12
<b>X. ORAL &amp; MAXILLOFACIAL SURGERY</b>							
D7111	extraction, coronal remnants – primary tooth		5	0	10	10	8
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)		7	0	16	16	10
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		25	0	40	40	30
D7220	removal of impacted tooth – soft tissue		40	25	50	50	40
D7230	removal of impacted tooth – partially bony		50	40	NTCV	65	50

**UNITEDHEALTHCARE / PACIFICARE DHMO**  
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**



**Dental Benefit  
Providers of California**

**EXHIBIT 2 - PART VI**

CDT Code	Plan Name Copayment Schedule Agreement ID:	Supplemental Payment	DENTAL 144	DENTAL 146	DENTAL 160	DENTAL 161	590H
			SFSGD0000003	SFSGD0000018	SFSGD0000019	SFSGD0000020	SFSGD0000015
			Member Copayment				
D7240	removal of impacted tooth – completely bony		75	50	NTCV	90	75
D7241	removal of impacted tooth – completely bony, with unusual surgical complications		75	50	NTCV	90	75
D7250	removal of residual tooth roots (cutting procedure)		40	25	40	40	30
D7285	incisional biopsy of oral tissue – hard (bone, tooth)		15	10	16	16	10
D7286	incisional biopsy of oral tissue – soft		6	5	10	10	6
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		50	0	90	90	70
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		38	0	68	68	53
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		70	50	80	80	80
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		53	38	60	60	60
D7471	removal of lateral exostosis (maxilla or mandible)		60	40	115	115	100
D7472	removal of torus palatinus		60	40	115	115	100
D7473	removal of torus mandibularis		60	40	115	115	100
D7485	reduction of osseous tuberosity		60	40	115	115	100
D7510	incision and drainage of abscess – intraoral soft tissue		10	5	30	30	14
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		15	8	45	45	NTCV
D7520	incision and drainage of abscess – extraoral soft tissue		NTCV	NTCV	30	30	14
D7521	incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		NTCV	NTCV	45	45	21
D7881	occlusal orthotic device adjustment		0	0	12	12	0
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure		20	10	50	50	25
D7972	surgical reduction of fibrous tuberosity		60	40	115	115	100
<b>XII. ADJUNCTIVE GENERAL SERVICES</b>							
D9110	palliative (emergency) treatment of dental pain – minor procedure		5	5	10	10	5
D9211	regional block anesthesia		0	0	0	0	0
D9212	trigeminal division block anesthesia		0	0	0	0	0
D9215	local anesthesia in conjunction with operative or surgical procedures		0	0	0	0	0
D9219	evaluation for deep sedation or general anesthesia		15	10	NTCV	25	25
D9222	deep sedation/general anesthesia – first 15 minutes		150	150	150	150	150

**UNITEDHEALTHCARE / PACIFICARE DHMO**  
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**



**Dental Benefit  
Providers of California**

**EXHIBIT 2 - PART VI**

CDT Code	Plan Name Copayment Schedule Agreement ID:	Supplemental Payment	DENTAL 144	DENTAL 146	DENTAL 160	DENTAL 161	590H
			SFSGD0000003	SFSGD0000018	SFSGD0000019	SFSGD0000020	SFSGD0000015
			Member Copayment				
D9223	deep sedation/general anesthesia – each subsequent 15 minute increment		45	45	60	60	45
D9230	inhalation of nitrous oxide/anoxiolysis, analgesia		NTCV	NTCV	NTCV	NTCV	30
D9239	intravenous moderate (conscious) sedation/anesthesia – first 15 minutes		175	175	175	175	175
D9243	intravenous moderate (conscious) sedation/anesthesia – each subsequent 15 minute increment		53	53	53	53	53
D9248	non-intravenous conscious sedation		NTCV	NTCV	NTCV	NTCV	30
D9310	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		15	10	NTCV	25	25
D9311	consultation with a medical health care professional		0	0	0	0	5
D9430	office visit for observation (during regularly scheduled hours) – no other services performed		0	0	0	0	5
D9440	office visit – after regularly scheduled hours		20	20	20	20	10
D9450	case presentation, detailed and extensive treatment planning		0	0	0	0	0
D9930	treatment of complications (post-surgical) – unusual circumstances, by report		0	0	0	0	NTCV
D9943	occlusal guard adjustment		0	0	12	12	0
D9951	occlusal adjustment – limited		0	0	0	0	0
D9952	occlusal adjustment – complete		0	0	0	NTCV	NTCV
	Broken Appointment, with no prior notification at least 24 hrs before the scheduled appointment		20	20	20	20	0

**FOOTNOTE:** Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade. Members 16 years of age and older are limited to 7 crowns and/or pontics in any 12-month period and any single fixed bridge is limited to 4 units in length. **The supplemental reimbursement is in addition to this amount.**

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc.

## LIMITATION OF BENEFITS

Listed procedures in the Schedule of Principal Benefits and Coverages booklet are covered benefits only when diagnosed as appropriate treatment by your assigned dentist.

1. **PROPHYLAXIS** – Routine cleaning of teeth, including polishing and required supragingival (above the gum) and coronal scaling, is an allowable preventive benefit once every six months.
2. **FULL-MOUTH RADIOGRAPHS** (X-rays) are limited to once in a two-year period. Bitewing x-rays are limited to no more than one series of four in any six-month period.
3. **FLUORIDE TREATMENTS** are limited to only once per calendar year.
4. **PERIODONTAL SCALING AND ROOT PLANING** – Both procedures are allowable only when the need can be demonstrated radiographically and/or by pocket charting. There is a maximum of four quadrants per calendar year.
5. **PERIODONTAL MAINTENANCE PROCEDURES** - is a benefit following active therapy once every six months at the specialist's office when referred by the general dentist, or provided by the assigned general dentist.
6. **PROSTHETICS**
  - A. **REMOVABLE PROSTHETICS**
    - 1) Temporary or Transitional Dentures - Temporary or transitional full dentures are not a covered benefit. However, with some benefit packages, an exception is made for
      - a) Replaces natural, permanent, anterior teeth, during the healing period immediately after extraction or traumatic tooth loss; or
      - b) Replaces extracted or lost natural, permanent, anterior teeth for Members under 16 years of age.
    - 2) Laboratory Upgrades including specialized services for Dentures are not covered. Fees to the Member for upgrades will be limited to the additional laboratory fee charged to the Dentist by the dental laboratory for the upgrade. Upgrades include, but are not limited to:
      - a) Precious metal for removable appliance framework or a metal base for a full denture;
      - b) Personalization and characterization;
      - c) Specialized materials;
      - d) Specialized services or techniques involving precision attachments or stress breakers.
    - 3) Dentures, Replacement, Repairs and Relines
      - a) For existing full or partial dentures, the addition of new denture teeth is covered if a natural tooth or a denture tooth is lost. Replacement of an existing full or partial denture is covered only if the existing denture has been determined unserviceable and cannot be made serviceable, by the assigned Dentist. However, replacement of an unserviceable full or partial denture that is less than five years old is covered if the denture was provided by a UHC Participating Provider and is determined by UHC to be unserviceable because the diagnosis, treatment, fabrication, or placement rendered by that Dentist did not meet applicable standards of dental care. Note: Not applicable to the Dental 160 Plan
      - b) If an existing permanent denture needs to be repaired and/or relined to be made serviceable, then repairs and/or relines are also a benefit. The addition of denture teeth, repairs and relines of secondary ("back-up," "spare" or "temporary") dentures are not covered benefits.
      - c) Denture adjustments – Adjustments for new dentures are included in the copayment for the denture for six months following delivery. For existing dentures, or new dentures after the initial six months, the Member is responsible for the listed copayment for a denture adjustment. Adjustments of secondary ("back-up," "spare") dentures are not a covered benefit.
  - B. **FIXED PROSTHETICS**
    - 1) A fixed bridge is a benefit to replace missing natural teeth, unless based upon professionally recognized standards:
      - a) The clinical condition of the teeth that would support the bridge is unfavorable.
      - b) There are inadequate teeth available to support the bridge.
      - c) The same dental arch has a serviceable existing partial denture to which additional denture teeth may be added to replace the missing natural teeth.
      - d) A bridge would be used only to realign malaligned teeth.

- e) The new bridge would replace an existing bridge that is less than five years old, regardless of whether the bridge is serviceable or unserviceable. However, replacement of an unserviceable bridge that is less than five years old is covered if the bridge was provided by a UHC Participating Provider and is determined by UHC to be unserviceable because the diagnosis, treatment, fabrication, or placement rendered by that Provider did not meet applicable standards of dental care.

Note: Not applicable to the Dental 160 Plan

- 2) A fixed bridge is a benefit to replace missing natural teeth, unless:
  - a) The requested service is for a new bridge and a new partial denture in the same arch. In such cases the Covered Service is for a partial denture that would replace all missing teeth in the arch or multiple bridges.
  - b) A member under 16 years of age loses a permanent tooth; in which case an anterior stayplate or space maintainer would be the covered benefit to replace the missing tooth. If the bridge is placed, patient or guardian must pay the Dentist's billed charges.
  - c) The bridge would be supported in whole or in part by dental implants, or acid-etched bridge retainers (a "Maryland" bridge). A bridge would be used only to realign malaligned teeth.
  - d) It is a long-spanning bridge (anything beyond four (4) abutments and/or pontics).
  - e) The bridge would have an abutment (support) only on one side (cantilever bridge).

#### C. SINGLE CROWNS, INLAYS AND ONLAYS

Single crowns, inlays and onlays will be covered when there is not enough retentive quality left in a tooth to hold a filling; or if the tooth requires cuspal protection to avoid an unacceptable risk of tooth fracture. The use of specialized materials (i.e. precious or semi-precious metals in crowns) is considered a laboratory upgrade, which the assigned Dentist may offer the Member for a fee not to exceed the amount charged to the Dentist by the dental laboratory for the use of these upgraded materials. Fees to the Member for upgrades will be limited to the additional laboratory fee charged to the Dentist by the dental laboratory for the upgrade. For example, the Dentist offers, and the Member accepts, the alternative of a precious (gold) crown instead of a base metal crown. The Dentist may charge no more than the listed copayment for the base metal crown, plus the actual fee charged by the dental laboratory for the use of the precious metal and/or any other specialized material.

- 1) Porcelain, porcelain-fused to metal (PFM), and cast metal crowns are not a benefit for children under 16 years of age. The benefit in such cases is a prefabricated stainless steel or resin crown. If a porcelain, PFM, or cast metal crown is performed, the parent or guardian must pay the Dentist's Billed Charges.
  - 2) For crowns and fixed bridges, the maximum benefit within a twelve month period is any combination of seven (7) crowns or pontics (artificial teeth that are part of a fixed bridge). If more than seven (7) crowns and/or pontics are done for a Member within a twelve month period, the Dentist's fee for any additional crowns within that period would not be limited to the listed copayment, but instead can reflect the Dentist's Billed Charges.
  - 3) Replacement of an inlay, onlay or porcelain or PFM crown is a covered benefit as long as the existing restoration is at least five years old, unserviceable, and cannot be made serviceable, as determined by the assigned Dentist. However, replacement of an existing unserviceable inlay, onlay, porcelain or PFM crown that is less than five years old is covered if the item was provided by a UHC Participating Provider and is determined by UHC to be unserviceable because the diagnosis, treatment, fabrication, or placement rendered by that Provider did not meet applicable standards of dental care. Note: Not applicable to the Dental 160 Plan
- 7. **OCCUSAL EQUILIBRATION** – This means the reshaping of the biting surfaces of the teeth to create harmonious contact and relationships between teeth in the upper and lower jaw. Adjustment of the bite on a new restoration, crown, bridge and denture will be provided at no additional charge, if performed by the Dentist who provided the service. The correction of occlusion on natural teeth or existing restorations is not a covered service.
  - 8. **DOWEL POSTS AND PINS** – Dowel posts are a benefit for teeth that have had root canal therapy and lack sufficient structure to otherwise support and retain a crown. Pins are a separate covered benefit deemed necessary by the Dentist to provide adequate retention of a restoration.
  - 9. **SPECIALTY REFERRAL:** The liability of UHC is per calendar year, per family above the Member's copayment for such specialty treatment. Any fees in excess of the copayment and UHC's liability are the responsibility of the Member. The Member's Specialty Family Calendar Year Maximum is listed in the Member's Schedule of Principal Benefits and Coverage. The benefit of dental treatment by a specialist is limited to:



A Member whose benefit package includes specialty referral benefits. Covered Dental Services performed by an Oral Surgeon, Endodontist, Periodontist and Pedodontist, - which are beyond the scope of a general practice dentist; and services by an Orthodontist, if the Member's benefit package specifically includes UHC's orthodontic benefit.

- Pedodontic referrals apply to all children through age 18 as necessary.

10. **RESTORATIONS AND DENTAL PROSTHETICS** – Restorations and/or fixed or removable prosthetics needed solely to increase vertical dimension or restore the occlusal plane are not covered benefits. Restoration of the occlusal plane means oral rehabilitation using crown(s), bridge(s), filling(s) and/or denture(s) to establish an altered bite or relationship between the jaws.
11. **IV SEDATION OR GENERAL ANESTHESIA** – Administration of IV sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).

## EXCLUSION OF BENEFITS

The following procedures and services are excluded and not covered benefits:

1. Specialty referral benefits are not available unless otherwise indicated in the Schedule of Principal Benefits and Coverage.
2. Services provided by a Prosthodontist.
3. Cosmetic dental care.
4. Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities or Members' homes. When deemed necessary by the Member's Dentist, the Member's physician, and authorized by UHC, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
5. Treatment of fractured bones and dislocated joints.
6. Lost or stolen dentures.
7. Crowns, or bridgework lost, stolen, or damaged due to Member abuse, misuse or neglect are not covered, unless the crown or bridge became dislodged because of recurrent dental caries, tooth fracture, substandard tooth preparation or poor margins (as previously determined in an examination by the Dentist or based upon a review of a pre-existing radiograph).
8. Lost, stolen or broken orthodontic appliances.
9. Services provided to the Member by a state government or agency thereof, or are provided without cost to the Member by a municipality, county or other subdivision.
10. Charges for services rendered after termination of the Member's eligibility under the Dental Plan.
11. Work-in-progress: Dental expenses incurred in connection with any portion of the dental services started prior to the effective date of coverage are excluded. The completion of dental or orthodontia services started before the Member's effective date of coverage with UHC, or started by a Non-Participating Provider without the prior approval of UHC. Note, this exclusion does not apply to a current Member who has temporary restorative services, whose tooth was opened and medicated as a palliative service while out-of-area or when the assigned Dentist is unavailable to render palliative care.
12. The treatment of congenital and/or developmental malformations, which includes, but is not limited to the treatment of congenitally missing and extra, supernumerary teeth and related pathology.
13. The treatment of non-dentigerous cysts, benign and malignant tumors, neoplasms and dysplasias.
14. Dental ridge augmentation, vestibuloplasties and the excision of benign hyperplastic tissue.
15. Prescription drugs and over-the-counter medicines.
16. Any dental procedure unable to be performed in the dental office because of the patient's general health and physical limitations.
17. Oral surgery and procedures performed to facilitate or allow orthodontic treatment, which include, but are not limited to: orthodontic extraction, serial extraction, orthognathic surgery, transeptal fiberotomy, gingivectomy, and surgery to uncover impacted teeth.
18. Services rendered by a dental office other than Member's assigned Dentist are not covered. An exception is made for Emergency Dental Care, as defined in the Combined Evidence of Coverage and Disclosure Form.

19. The placement, maintenance, and removal of implants or crowns and fixed prosthetics supported by implants.
20. Restorations to replace or stabilize tooth structure lost solely by abrasion or erosion. Restorations of natural teeth other than those noted herein.
21. Periodontal splinting/grafting.
22. Replacement of amalgam restorations with different materials solely to eliminate the presence of amalgam.
23. Restorations and dental prosthetics that are done solely to alter the vertical dimension of occlusion, alter the plane of occlusion, modify a parafunctional habit, and/or treat temporomandibular joint dysfunction and/or myofascial pain syndrome are not covered benefits. If performed, the Member must pay the Dentist's Billed Charges. These services include:
  - a) Realignment of teeth, gnathologic recording, equilibration, occlusal splints and night guards, overlays, implant supported partial dentures and overdentures, the replacement of otherwise serviceable existing restorations and dental prosthetics, and precision attachments and stressbreakers.
24. Dental services that the Plan or Participating Provider determines not to be medically necessary or consistent with good professional practice.
25. Dental services that would not be consistent with the individual Member's dental needs and/or generally accepted professional standards of dental therapeutics for that Member.
26. The premature extraction of asymptomatic or non-pathologic impacted teeth at an early stage of tooth development, which, if allowed to further develop and erupt, would reduce the likelihood of needing a more invasive surgery and/or experiencing post-operative complications.
27. Adjunctive dental services that are performed only to allow or facilitate the performance of another non-covered dental service. Medical services for treatment of fractures, dislocations, tumors, non-dentigerous cysts and neoplasms, and other medically necessary surgeries of the jaws or related joints are not covered. Requests for such services should be submitted to the Member's full service medical health plan.
28. Liability insurance cases: Dental care which is covered under automobile, medical, no-fault or similar type insurance is excluded from coverage under this Dental Plan.

## OPTIONAL, UPGRADED OR ALTERNATIVE TREATMENT DISCLOSURE FORM

Patient's Name:	ID:	<b>United Healthcare</b>   <b>Dental Benefit Providers of California</b>
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Treatment Plan No.:	Chart ID No.:
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### I. FORMULA for DETERMINING CHARGES for OPTIONAL, UPGRADED or ALTERNATIVE TREATMENT:

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

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

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

### II. METAL UPGRADES (for crowns, bridge abutments & pontics)

When a Member elects a laboratory upgrade of a standard covered service, please use the following formula to determine the charge:

Some plans only allow a metal laboratory upgrade charge (e.g. Blue Shield 65 Plus, plans with version 5 Limitations). Metal Upgrades are based on the additional cost of the metal. In these instances please use the following formula to determine the charge:

Copayment [1] + Metal Upgrade [2] = Accepted fee [3]

				1	2	3
CDT Code of Proposed Treatment	Proposed Procedure Description	Tooth No. or Area	UCR Fee of Proposed Treatment	Copayment of Benefit	Additional Charge for Metal Upgrade	Accepted Charge

\*Reason for Upgrade / Reason proposed service is not covered:

I agree to the above charges which represent additional financial obligations for treatment or features that I desire that are not part of my dental benefit plan.

Patient's (Parent or Guardian) Signature:	Date:
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Treatment Plan presented by DDS:	Date:
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