**UNITEDHEALTHCARE / PACIFICARE DHMO**
**AARP MEDICARE COMPLETE (SECURE HORIZONS) DHMO**
**LINCOLN FINANCIAL GROUP DHMO**
**QUICK REFERENCE GUIDE (QRG)**

| | UnitedHealthcare | Lincoln Financial Group (Lincoln Dental Connect) | AARP Medicare Complete (Secure Horizons) | UHC Pacificare & UHC Dental Individual Membership |
|---|---|---|---|---|
| **Client Name on Capitation Roster:** | USS<br>UHC West<br>UnitedHealthcare | Lincoln Financial Group | Ovations | UnitedHealthcare<br>UHC Dental Individual Membership |
| **Website:**<br>Offers eligibility verification, claim status and network specialist locations. | **www.uhcdental.com** | | | |
| **Using our website to locate Dentists including Specialists:**<br>Before Log in, select "Provider Search", "State", and "Select A Network". | **CA SELECT MANAGED CARE DHMO PLAN**<br>**CA DHMO PEDIATRIC EHB & FAMILY BUY UP** | | **CA DHMO AARP MEDICARE COMPLETE** | **CA DHMO-LEGACY PACIFICARE** |
| **Specialty Referral Process:** | **PRE-AUTHORIZATION** | | | |
| **Member ID Cards:**<br>The following brand names are found on the member ID cards for your reference. | UnitedHealthcare | Lincoln Financial Group | AARP MedicareComplete through UnitedHealthcare | UnitedHealthcare |
| **Integrated Voice Response (IVR) System**<br>• Enables you to access information 24 hours a day<br>• Obtain real-time eligibility, eligibility via fax, and assign members to your office<br>• Obtain claim status and copies of EOB's | **1-877-732-4337** | **1-888-877-7828** | **1-877-732-4337** | **1-877-732-4337** |
| **Dedicated Toll Free Customer Service:**<br>Issues such as eligibility, claims and dental plan information. | **1-877-732-4337** | **1-888-877-7828** | **1-877-732-4337** | **1-877-732-4337** |
| **Provider Relations:**<br>Questions regarding fee schedules, monthly rosters and contracts | **1-877-732-4337** | **1-888-877-7828** | **1-877-732-4337** | **1-877-732-4337** |
| **Emergency Specialty Referral Phone Number:** | **1-877-732-4337** | **1-888-877-7828** | **1-877-732-4337** | **1-877-732-4337** |
| **Request for Specialty Referral Form and Provider Manual:** | **1-877-732-4337** | **1-888-877-7828** | **1-877-732-4337** | **1-877-732-4337** |
| **Address:**<br>Encounter Data/Minimum Guarantee/Supplemental Claims | **P.O. Box 30567**<br>**Salt Lake City, UT 84130-0567** | | | |
| **Address:**<br>Specialty Referral and Pre-Treatment Estimates | **P.O. Box 30552**<br>**Salt Lake City, UT 84130-0552** | | | |
| **Address:**<br>Written Inquiries and Appeals | **P.O. Box 30569**<br>**Salt Lake City, UT 84130-0569** | | | |
| **Electronic Claims Submission - Payor ID:** | **52133** | | | |
| **California Language Assistance Program:**<br>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. | | | | |
| **Benefits for the UnitedHealthcare Dental DHMO/Direct Compensation plans are offered by Dental Benefit Providers of California, Inc.**<br>**UnitedHealthcare Dental is affiliated with UnitedHealthcare.** | | | | |
| All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed to any other individual and/or third party without the express written consent of Dental Benefit Providers of CA, Inc. | | | | |

# UNITEDHEALTHCARE DHMO
# CAPITATION CROSSWALK / PER MEMBER-PER MONTH (PMPM)
# 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 |
|---|---|---|---|---|---|---|---|---|
| D0010897 | UnitedHealthcare | Laguna 110C | DMOCARG00001 | $3.53 | Yes | No | Pre-Auth | Commercial |
| D0010996 | UnitedHealthcare | Laguna 110C | DMOCARG00001 | $3.53 | 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 |
| D0010852 | UnitedHealthcare | Malibu 130C | DMOCARG00003 | $4.12 | Yes | No | Pre-Auth | Commercial |
| D0010999 | UnitedHealthcare | Malibu 130C | DMOCARG00003 | $4.12 | Yes | No | Pre-Auth | Commercial |
| D0010842 | UnitedHealthcare | Newport 120C | DMOCARG00004 | $3.85 | Yes | No | Pre-Auth | Commercial |
| D0010859 | UnitedHealthcare | Newport 120C | DMOCARG00004 | $3.85 | 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 |
| 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 |
| D0010815 | UnitedHealthcare | Pismo 140C | DMOCARG00007 | $4.45 | Yes | No | Pre-Auth | Commercial |
| D0010844 | UnitedHealthcare | Pismo 140C | DMOCARG00007 | $4.45 | 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 |
| 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 |
| D0010881 | UnitedHealthcare | Laguna 110 | DMOCARG00010 | $3.75 | Yes | No | Pre-Auth | Commercial |
| D0010995 | UnitedHealthcare | Laguna 110 | DMOCARG00010 | $3.75 | Yes | No | Pre-Auth | Commercial |
| 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 |
| D0010997 | UnitedHealthcare | Newport 120 | DMOCARG00012 | $4.07 | Yes | No | Pre-Auth | Commercial |
| D0010998 | UnitedHealthcare | Newport 120 | DMOCARG00012 | $4.07 | 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 |
| D0010898 | UnitedHealthcare | Pismo 140 | DMOCARG00014 | $4.67 | Yes | No | Pre-Auth | Commercial |
| D0011000 | UnitedHealthcare | Pismo 140 | DMOCARG00014 | $4.67 | 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 |
| 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 |
| 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 |
| D0011001 | UnitedHealthcare | Malibu 130 | DMOCARG00018 | $4.34 | Yes | No | Pre-Auth | Commercial |
| D0011002 | UnitedHealthcare | Malibu 130 | DMOCARG00018 | $4.34 | Yes | No | Pre-Auth | Commercial |
| D0012794 | UnitedHealthcare | UHC AON Exchange CA DHMO Plan 130 | DMOCARG00018 | $4.34 | Yes | No | Pre-Auth | Commercial |
| D0014814 | UnitedHealthcare | UHC Standard 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 |
| E0016739 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0016740 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0016745 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |

# UNITEDHEALTHCARE DHMO
# CAPITATION CROSSWALK / PER MEMBER-PER MONTH (PMPM)
# 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 |
|---|---|---|---|---|---|---|---|---|
| E0019180 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0019181 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0019182 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0019183 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0019184 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0019185 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0019186 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0019187 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0019188 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0019189 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0019190 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0019191 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020679 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020680 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020681 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020682 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020683 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020684 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020685 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020686 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020687 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020688 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020689 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020690 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020691 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020692 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020693 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020694 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020695 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020696 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020697 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020698 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0020699 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0021000 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0021001 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0021002 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0021003 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0021004 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0021005 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0021006 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0021007 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0021011 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0022805 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |

# UNITEDHEALTHCARE DHMO
# CAPITATION CROSSWALK / PER MEMBER-PER MONTH (PMPM)
# 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 |
|---|---|---|---|---|---|---|---|---|
| E0022806 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0022807 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0022808 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0022809 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0022810 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0022811 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0022812 | UnitedHealthcare | UHC 2018 CA EHB DHMO | SCFG00000263 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024762 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024763 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024764 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024765 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024766 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024767 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024768 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024769 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024770 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024771 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024772 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024773 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024774 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024775 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024776 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024777 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024778 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024779 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024780 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024781 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024782 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024783 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024784 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024785 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024786 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024787 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024788 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024789 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024790 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024791 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024792 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024793 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024794 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024795 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024796 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024797 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |

# UNITEDHEALTHCARE DHMO
# CAPITATION CROSSWALK / PER MEMBER-PER MONTH (PMPM)
# 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 |
|---|---|---|---|---|---|---|---|---|
| E0024798 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024799 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0024800 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025103 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025104 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025105 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025106 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025107 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025108 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025109 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025110 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025111 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025112 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025113 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025114 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025119 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025120 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025121 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025122 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025123 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025124 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025125 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025126 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025127 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025128 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025129 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| E0025130 | UnitedHealthcare | UHC 2019 CA EHB DHMO | SCFG00000698 | $3.10 (Child 0-19) | Yes | No | Pre-Auth | EHB |
| D0012023 | AARP Medicare Complete Secure Horizons (Ovations) | SH100 Retiree | SFSGD0000002 | $0.00 | No | Yes* | Not Covered | Medicare |
| D0012018 | UnitedHealthcare (PacifiCare) | UHC DENTAL 144 | SFSGD0000003 | $3.83 | No | Yes | Pre-Auth | Commercial |
| D0012025 | AARP Medicare Complete Secure Horizons (Ovations) | High Option | SFSGD0000004 | $6.15 | No | Yes | Prior-Auth | Medicare |
| D0012024 | AARP Medicare Complete Secure Horizons (Ovations) | Optional | SFSGD0000005 | $0.50 | No | Yes* | Not Covered | Medicare |
| D0012660 | AARP Medicare Complete Secure Horizons (Ovations) | Optional | SFSGD0000005 | $0.50 | No | Yes* | Not Covered | Medicare |
| D0012017 | UnitedHealthcare (PacifiCare) | UHC DENTAL 142 | SFSGD0000007 | $3.42 | No | Yes | 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 |
| D0012015 | UnitedHealthcare (PacifiCare) | UHC DENTAL 140 | SFSGD0000014 | $2.41 | No | Yes | Pre-Auth | Commercial |
| D0012027 | UnitedHealthcare (PacifiCare) | UHC 590H | SFSGD0000015 | $6.00 | No | No | Pre-Auth | Commercial |
| D0012016 | UnitedHealthcare (PacifiCare) | UHC DENTAL 142 FEDS | SFSGD0000016 | $3.65 | No | Yes | Pre-Auth | Commercial |

# UNITEDHEALTHCARE DHMO
# CAPITATION CROSSWALK / PER MEMBER-PER MONTH (PMPM)
# 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 |
|---|---|---|---|---|---|---|---|---|
| D0012020 | UnitedHealthcare (PacifiCare) | UHC DENTAL 146 | SFSGD0000018 | $4.80 | No | Yes | 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 |

*Encounter Fee Supplemental Only

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

| Customer Service Phone Number 1-877-732-4337 | | Plan Name<br>Agreement ID | Laguna 110C<br>DMOCARG00001<br>Laguna 110<br>DMOCARG00010 | Newport 120C<br>DMOCARG00004<br>Newport 120<br>DMOCARG00012 | Malibu 130C<br>DMOCARG00003<br>Malibu 130<br>DMOCARG00018 | Pismo 140C<br>DMOCARG00007<br>Pismo 140<br>DMOCARG00014 | Santa Cruz 150C<br>DMOCARG00006<br>Santa Cruz 150<br>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 [1] | Member Copayment | | | | |
| **I. DIAGNOSTIC** | | | | | | | |
| 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 |

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**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<br>DMOCARG00001<br>Laguna 110<br>DMOCARG00010 | Newport 120C<br>DMOCARG00004<br>Newport 120<br>DMOCARG00012 | Malibu 130C<br>DMOCARG00003<br>Malibu 130<br>DMOCARG00018 | Pismo 140C<br>DMOCARG00007<br>Pismo 140<br>DMOCARG00014 | Santa Cruz 150C<br>DMOCARG00006<br>Santa Cruz 150<br>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 [1] | Member Copayment | | | | |
| 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 |
| 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<br>*Member is responsible for $5.00 office visit fee for Plan Name ending in "C" (e.g. Laguna 110C). | 2 | 0/5[2] | 0/5[2] | 0/5[2] | 0/5[2] | 0/5[2] |

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

| Customer Service Phone Number 1-877-732-4337 | | Plan Name<br>Agreement ID | Laguna 110C<br>DMOCARG00001<br>Laguna 110<br>DMOCARG00010 | Newport 120C<br>DMOCARG00004<br>Newport 120<br>DMOCARG00012 | Malibu 130C<br>DMOCARG00003<br>Malibu 130<br>DMOCARG00018 | Pismo 140C<br>DMOCARG00007<br>Pismo 140<br>DMOCARG00014 | Santa Cruz 150C<br>DMOCARG00006<br>Santa Cruz 150<br>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 [1] | Member Copayment | | | | |
| **II. PREVENTIVE** | | | | | | | |
| *** Additional Prophy within 6 months will be based upon the necessity recommended by the provider.** | | | | | | | |
| D1110 | prophylaxis – adult | | 5 | 0 | 0 | 0 | 0 |
| -------- | prophylaxis - adult: Additional Prophy within 6 months* | | 25 | 25 | 25 | 25 | 25 |
| D1120 | prophylaxis – child | | 5 | 0 | 0 | 0 | 0 |
| -------- | 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 |
| **III. RESTORATIVE** | | | | | | | |
| ***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 |

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| Customer Service Phone Number 1-877-732-4337 | | Plan Name<br>Agreement ID | Laguna 110C<br>DMOCARG00001<br>Laguna 110<br>DMOCARG00010 | Newport 120C<br>DMOCARG00004<br>Newport 120<br>DMOCARG00012 | Malibu 130C<br>DMOCARG00003<br>Malibu 130<br>DMOCARG00018 | Pismo 140C<br>DMOCARG00007<br>Pismo 140<br>DMOCARG00014 | Santa Cruz 150C<br>DMOCARG00006<br>Santa Cruz 150<br>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 [1] | Member Copayment | | | | |
| 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 |
| 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 |

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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 [1] | Member Copayment | | | | |
| 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 |
| 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 |
| **IV. ENDODONTICS** | | | | | | | |
| 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 |

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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 [1] | Member Copayment | | | | |
| 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 |
| 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/calcific 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/calcific 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 |
| **V. PERIODONTICS** | | | | | | | |
| 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 |

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**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<br>DMOCARG00001<br>Laguna 110<br>DMOCARG00010 | Newport 120C<br>DMOCARG00004<br>Newport 120<br>DMOCARG00012 | Malibu 130C<br>DMOCARG00003<br>Malibu 130<br>DMOCARG00018 | Pismo 140C<br>DMOCARG00007<br>Pismo 140<br>DMOCARG00014 | Santa Cruz 150C<br>DMOCARG00006<br>Santa Cruz 150<br>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 [1] | Member Copayment | | | | |
| 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 |
| 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 [1] | Member Copayment | | | | |
| **VI. PROSTHODONTICS, REMOVABLE**<br>*** 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 | 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 |

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|---|---|---|---|---|---|---|---|
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| CDT Code | Description | Minimum Guarantee [1] | Member Copayment | | | | |
| D5612 | repair resin partial denture base, maxillary | | 40 | 35 | 30 | 25 | 15 |
| D5621 | repair cast partial framework, mandibular | | 40 | 35 | 30 | 25 | 15 |
| 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 |
| **VIII. IMPLANT SERVICES** | | | | | | | |
| 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 |

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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 [1] | Member Copayment | | | | |
| 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 |
| 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 |

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|---|---|---|---|---|---|---|---|
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| CDT Code | Description | Minimum Guarantee [1] | Member Copayment | | | | |
| 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 |
| 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 |
| **IX. PROSTHODONTICS, FIXED** | | | | | | | |
| ***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 |

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|---|---|---|---|---|---|---|---|
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| CDT Code | Description | Minimum Guarantee [1] | Member Copayment | | | | |
| 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 |
| 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 |

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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 [1] | Member Copayment | | | | |
| D6980 | fixed partial denture repair necessitated by restorative material failure | | 140 | 140 | 140 | 140 | 140 |
| **X. ORAL & MAXILLOFACIAL SURGERY** | | | | | | | |
| 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 |
| 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 |

[1] 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 DMOCARG00001 Laguna 110 DMOCARG00010 | Newport 120C DMOCARG00004 Newport 120 DMOCARG00012 | Malibu 130C DMOCARG00003 Malibu 130 DMOCARG00018 | Pismo 140C DMOCARG00007 Pismo 140 DMOCARG00014 | Santa Cruz 150C DMOCARG00006 Santa Cruz 150 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 [1] | Member Copayment | | | | |
| 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 |
| 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 |
| **XII. ADJUNCTIVE GENERAL SERVICES** | | | | | | | |
| 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 |

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

| Customer Service Phone Number 1-877-732-4337 | | Plan Name<br>Agreement ID | Laguna 110C<br>DMOCARG00001<br>Laguna 110<br>DMOCARG00010 | Newport 120C<br>DMOCARG00004<br>Newport 120<br>DMOCARG00012 | Malibu 130C<br>DMOCARG00003<br>Malibu 130<br>DMOCARG00018 | Pismo 140C<br>DMOCARG00007<br>Pismo 140<br>DMOCARG00014 | Santa Cruz 150C<br>DMOCARG00006<br>Santa Cruz 150<br>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 [1] | Member Copayment | | | | |
| 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 |
| 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.





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**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 [1] | Member Copayment | | | |
| **I. DIAGNOSTIC** | | | | | | |
| D0120 | periodic oral evaluation – established patient | | 0 | 0 | 0 | 0 |
| D0140 | limited oral evaluation – problem focused | | 0 | 0 | 0 | 0 |
| D0145 | oral evaluation for a patient under three years of age and counseling with primary caregiver | | 0 | 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 |



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**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<br>DMOCARG00005<br>Plan 450<br>DMOCARG00011 | Plan 550C<br>DMOCARG00008<br>Plan 550<br>DMOCARG00013 | Plan 650C<br>DMOCARG00009<br>Plan 650<br>DMOCARG00015 | Plan 750C<br>DMOCARG00002<br>Plan 750<br>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 [1] | Member Copayment | | | |
| 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 |
| 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<br>*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* |
| **II. PREVENTIVE**<br>*** 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 |



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**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 DMOCARG00005 Plan 450 DMOCARG00011 | Plan 550C DMOCARG00008 Plan 550 DMOCARG00013 | Plan 650C DMOCARG00009 Plan 650 DMOCARG00015 | Plan 750C DMOCARG00002 Plan 750 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 [1] | Member Copayment | | | |
| D1575 | distal shoe space maintainer – fixed – unilateral | | 32 | 25 | 20 | 0 |
| **III. RESTORATIVE** | | | | | | |
| ***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 |



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

UnitedHealthcare®

| 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 [1] | Member Copayment | | | |
| 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 |
| 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 |



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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 [1] | Member Copayment | | | |
| 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 |
| **IV. ENDODONTICS** | | | | | | |
| 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 |



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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 [1] | Member Copayment | | | |
| 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 |
| **V. PERIODONTICS** | | | | | | |
| 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 |



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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 [1] | Member Copayment | | | |
| 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 |
| **VI. PROSTHODONTICS (REMOVABLE)** | | | | | | |
| * 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 |



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|---|---|---|---|---|---|---|
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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 [1] | Member Copayment | | | |
| 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 |
| 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 |
| **VIII. IMPLANT SERVICES** | | | | | | |
| 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 |



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|---|---|---|---|---|---|---|
| | | | 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 [1] | Member Copayment | | | |
| 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 |
| 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 |



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| | | | DMOCARG00011 | DMOCARG00013 | DMOCARG00015 | DMOCARG00017 |
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| CDT CODE | Description | Minimum Guarantee [1] | Member Copayment | | | |
| 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 |
| **IX. PROSTHODONTICS, FIXED** | | | | | | |
| *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 |



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| | | | DMOCARG00011 | DMOCARG00013 | DMOCARG00015 | DMOCARG00017 |
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| CDT CODE | Description | Minimum Guarantee [1] | Member Copayment | | | |
| 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 |
| 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 |
| **X. ORAL & MAXILLOFACIAL SURGERY** | | | | | | |
| 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 |



[1] 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 [1] | Member Copayment | | | |
| 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 |
| D7310 | alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | | 50 | 35 | 15 | 0 |
| D7311 | alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | | 45 | 10 | 10 | 0 |
| D7320 | alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | | 70 | 50 | 30 | 0 |
| D7321 | alveoloplasty 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 |



[1] 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 [1] | Member Copayment | | | |
| D7972 | surgical reduction of fibrous tuberosity | | 100 | 95 | 85 | 40 |
| **XII. ADJUNCTIVE GENERAL SERVICES** | | | | | | |
| 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/anxiolysis, analgesia | | 30 | 30 | 30 | 30 |
| 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.





[1] DBP will pay your office the difference between the Minimum Guarantee listed above and the Member's Copay.

# UNITEDHEALTHCARE / LINCOLN FINANCIAL GROUP DHMO
# EXCLUSIONS AND LIMITATIONS
# EXHIBIT 2

## 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.
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. 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.

# AARP MEDICARE COMPLETE - SECURE HORIZONS DHMO (OVATIONS)
# PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
# EXHIBIT 2 - PART III

| CDT CODE | CDT DESCRIPTION PLAN NAME: | SH 100 Retiree | Optional | Hi-Option | Hi-Option Supplemental |
|---|---|---|---|---|---|
| | CDT codes not listed are not a covered benefit Agreement ID: | SFSGD0000002 | SFSGD0000005 | SFSGD0000004 | SFSGD0000004 |
| | SPECIALTY REFERRAL PROCESS ($1000 Calendar Year Maximum excluding Orthodontia): | NTCV | NTCV | PRE-AUTH | |
| 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 | | | |
| D0999 | Encounter Fee | 0 | 0 | 0 | |
| | Office Visit (see limitation at end of document) | 5 | 5 | 5 | |
| | Initial charting with pocket depth summary | 10 | 10 | 10 | |
| | Broken Appointment, with no prior notification at least 24 hrs before the scheduled appointment | 0 | 0 | 0 | |
| **I. DIAGNOSTIC** | | | | | |
| D0120 | periodic oral evaluation – established patient | 8 | 8 | 0 | |
| D0140 | limited oral evaluation – problem focused | 11 | 10 | 0 | |
| D0145 | oral evaluation for a patient under three years of age and counseling with primary caregiver | NTCV | 10 | 0 | |
| D0150 | comprehensive oral evaluation – new or established patient | 10 | 8 | 0 | |
| D0160 | detailed and extensive oral evaluation – problem focused, by report | 12 | 10 | 0 | |
| D0170 | re-evaluation – limited, problem focused (established patient; not post-operative visit) | 11 | 8 | 0 | |
| D0171 | re-evaluation – post-operative office visit | NTCV | 5 | 0 | |
| D0180 | comprehensive periodontal evaluation – new or established patient | 10 | 8 | 0 | |
| D0210 | intraoral – complete series of radiographic images | 22 | 15 | 0 | |
| D0220 | intraoral – periapical first radiographic image | 5 | 5 | 0 | |
| D0230 | intraoral – periapical each additional radiographic image | 3 | 3 | 0 | |
| D0240 | intraoral – occlusal radiographic image | 6 | 6 | 0 | |
| D0270 | bitewing – single radiographic image | 5 | 3 | 0 | |
| D0272 | bitewings – two radiographic images | 9 | 7 | 0 | |
| D0273 | bitewings – three radiographic images | NTCV | 9 | 0 | |
| D0274 | bitewings – four radiographic images | 11 | 11 | 0 | |
| D0330 | panoramic radiographic image | 18 | 15 | 0 | |
| D0460 | pulp vitality tests | 8 | 10 | 0 | |
| **II. PREVENTIVE** | | | | | |
| D1110 | prophylaxis – adult | 15 | 15 | 5 | |
| D1206 | topical application of fluoride varnish | NTCV | NTCV | 10 | |
| D1208 | topical application of fluoride – excluding varnish | NTCV | NTCV | 10 | |
| D1330 | oral hygiene instructions | NTCV | 0 | 0 | |



NTCV = Not Covered

# AARP MEDICARE COMPLETE - SECURE HORIZONS DHMO (OVATIONS)
# PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
# EXHIBIT 2 - PART III

| CDT CODE | CDT DESCRIPTION PLAN NAME: | SH 100 Retiree | Optional | Hi-Option | Hi-Option Supplemental |
|---|---|---|---|---|---|
| | CDT codes not listed are not a covered benefit Agreement ID: | SFSGD0000002 | SFSGD0000005 | SFSGD0000004 | SFSGD0000004 |
| | SPECIALTY REFERRAL PROCESS ($1000 Calendar Year Maximum excluding Orthodontia): | NTCV | NTCV | PRE-AUTH | |
| 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 | | | |
| **III. RESTORATIVE** • 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. • 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. | | | | | |
| D2140 | amalgam – one surface, primary or permanent | 50 | 36 | 20 | |
| D2150 | amalgam – two surfaces, primary or permanent | 59 | 45 | 35 | |
| D2160 | amalgam – three surfaces, primary or permanent | 70 | 55 | 45 | |
| D2161 | amalgam – four or more surfaces, primary or permanent | 82 | 75 | 60 | |
| D2330 | resin-based composite – one surface, anterior | 64 | 65 | 30 | |
| D2331 | resin-based composite – two surfaces, anterior | 75 | 75 | 45 | |
| D2332 | resin-based composite – three surfaces, anterior | 84 | 85 | 50 | |
| D2335 | resin-based composite – four or more surfaces or involving incisal angle (anterior) | 94 | 95 | 65 | |
| D2391 | resin-based composite – one surface, posterior | 66 | 70 | 70 | |
| D2392 | resin-based composite – two surfaces, posterior | 85 | 85 | 85 | |
| D2393 | resin-based composite – three surfaces, posterior | 102 | 105 | 105 | |
| D2394 | resin-based composite – four or more surfaces, posterior | 117 | 115 | 115 | |
| D2510 | inlay – metallic – one surface | NTCV | NTCV | 200 | |
| D2520 | inlay – metallic – two surfaces | NTCV | NTCV | 200 | |
| D2530 | inlay – metallic – three or more surfaces | NTCV | NTCV | 200 | |
| D2542 | onlay – metallic – two surfaces | NTCV | NTCV | 200 | |
| D2543 | onlay – metallic – three surfaces | NTCV | NTCV | 200 | |
| D2544 | onlay – metallic – four or more surfaces | NTCV | NTCV | 200 | |
| D2710 | crown – resin-based composite (indirect) | 172 | 150 | 125 | 48 |
| D2712 | crown – ¾ resin-based composite (indirect) | 172 | 150 | 125 | |
| D2720 | crown – resin with high noble metal | 438 | 350 | 290 | 48 |
| D2721 | crown – resin with predominantly base metal | 385 | 350 | 290 | 48 |
| D2722 | crown – resin with noble metal | 438 | 350 | 290 | 48 |
| D2740 | crown – porcelain/ceramic | 487 | 500 | 250 | 48 |
| D2750 | crown – porcelain fused to high noble metal | 469 | 450 | 275 | 48 |
| D2751 | crown – porcelain fused to predominantly base metal | 447 | 450 | 275 | 48 |
| D2752 | crown – porcelain fused to noble metal | 455 | 450 | 275 | 48 |
| D2780 | crown – ¾ cast high noble metal | 459 | 460 | 250 | 48 |
| D2781 | crown – ¾ cast predominantly base metal | 459 | 460 | 250 | 48 |



NTCV = Not Covered

# AARP MEDICARE COMPLETE - SECURE HORIZONS DHMO (OVATIONS)
# PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
# EXHIBIT 2 - PART III

| CDT CODE | CDT DESCRIPTION PLAN NAME: | SH 100 Retiree | Optional | Hi-Option | Hi-Option Supplemental |
|---|---|---|---|---|---|
| | CDT codes not listed are not a covered benefit Agreement ID: | SFSGD0000002 | SFSGD0000005 | SFSGD0000004 | SFSGD0000004 |
| | SPECIALTY REFERRAL PROCESS ($1000 Calendar Year Maximum excluding Orthodontia): | NTCV | NTCV | PRE-AUTH | |
| 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 | | | |
| D2782 | crown – ¾ cast noble metal | 459 | 460 | 250 | 48 |
| D2783 | crown – ¾ porcelain/ceramic | 366 | 400 | 200 | 48 |
| D2790 | crown – full cast high noble metal | 461 | 450 | 275 | 48 |
| D2791 | crown – full cast predominantly base metal | 428 | 450 | 275 | 48 |
| D2792 | crown – full cast noble metal | 455 | 450 | 275 | 48 |
| D2794 | crown – titanium | 428 | 450 | 275 | 48 |
| D2915 | re-cement or re-bond indirectly fabricated or prefabricated post and core | 33 | 25 | 15 | |
| D2920 | re-cement or re-bond crown | 33 | 25 | 15 | |
| D2931 | prefabricated stainless steel crown – permanent tooth | 105 | 100 | 40 | |
| D2932 | prefabricated resin crown | 105 | 100 | 40 | |
| D2940 | protective restoration | 30 | 30 | 18 | |
| D2941 | interim therapeutic restoration – primary dentition | NTCV | NTCV | 18 | |
| D2950 | core buildup, including any pins when required | NTCV | NTCV | 65 | |
| D2951 | pin retention – per tooth, in addition to restoration | 23 | 25 | 10 | |
| D2952 | post and core in addition to crown, indirectly fabricated | 135 | 125 | 85 | |
| D2953 | each additional indirectly fabricated post – same tooth | 108 | 80 | 65 | |
| D2954 | prefabricated post and core in addition to crown | 108 | 100 | 65 | |
| D2957 | each additional prefabricated post – same tooth | 87 | 90 | 55 | |
| D2971 | additional procedures to construct new crown under existing partial denture framework | 100 | 100 | 100 | |
| D2975 | coping | 50 | NTCV | NTCV | |
| **IV. ENDODONTICS** | | | | | |
| • Surgical services include routine post-operative care | | | | | |
| D3110 | pulp cap – direct (excluding final restoration) | 27 | 25 | 12 | |
| D3120 | pulp cap – indirect (excluding final restoration) | 45 | 30 | 18 | |
| D3220 | therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament | 46 | 40 | 20 | |
| D3310 | endodontic therapy, anterior tooth (excluding final restoration) | 308 | 275 | 165 | |
| D3320 | endodontic therapy, premolar tooth (excluding final restoration) | 364 | 320 | 225 | |
| D3330 | endodontic therapy, molar tooth (excluding final restoration) | 490 | 425 | 350 | |
| D3332 | incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | 245 | 225 | 150 | |
| D3346 | retreatment of previous root canal therapy – anterior | NTCV | NTCV | 245 | |
| D3347 | retreatment of previous root canal therapy – premolar | NTCV | NTCV | 280 | |



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# AARP MEDICARE COMPLETE - SECURE HORIZONS DHMO (OVATIONS)
# PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
# EXHIBIT 2 - PART III

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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 | | | |
| D3348 | retreatment of previous root canal therapy – molar | NTCV | NTCV | 400 | |
| D3410 | apicoectomy – anterior | NTCV | NTCV | 200 | |
| D3421 | apicoectomy – premolar (first root) | NTCV | NTCV | 200 | |
| D3425 | apicoectomy – molar (first root) | NTCV | NTCV | 200 | |
| D3426 | apicoectomy (each additional root) | NTCV | NTCV | 80 | |
| D3427 | periradicular surgery without apicoectomy | NTCV | NTCV | 80 | |
| D3430 | retrograde filling – per root | NTCV | NTCV | 80 | |
| D3950 | canal preparation and fitting of preformed dowel or post | 60 | 100 | 0 | |
| **V. PERIODONTICS** | | | | | |
| • Surgical services include routine post-operative care | | | | | |
| D4210 | gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant | NTCV | NTCV | 180 | |
| D4211 | gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant | NTCV | NTCV | 45 | |
| D4240 | gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant | NTCV | NTCV | 175 | |
| D4241 | gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant | NTCV | NTCV | 85 | |
| D4260 | osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant | NTCV | NTCV | 500 | |
| D4261 | osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant | NTCV | NTCV | 250 | |
| D4341 | periodontal scaling and root planing – four or more teeth per quadrant | 90 | 85 | 40 | |
| D4342 | periodontal scaling and root planing – one to three teeth per quadrant | 45 | 45 | 20 | |
| D4355 | full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit | 50 | 50 | 40 | |
| D4910 | periodontal maintenance | 54 | 45 | 40 | |
| D4921 | gingival irrigation - per quadrant | NTCV | NTCV | 10 | |



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# AARP MEDICARE COMPLETE - SECURE HORIZONS DHMO (OVATIONS)
# PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
# EXHIBIT 2 - PART III

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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 | | | |
| **VI. PROSTHODONTICS (REMOVABLE)**<br>• 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.<br>• Includes post-delivery care and adjustments for the first 6 months (at the office delivering the removable prosthesis). | | | | | |
| D5110 | complete denture – maxillary | 528 | 525 | 310 | 108 |
| D5120 | complete denture – mandibular | 536 | 480 | 310 | 108 |
| D5130 | immediate denture – maxillary | 540 | 540 | 330 | 108 |
| D5140 | immediate denture – mandibular | 534 | 535 | 330 | 108 |
| D5211 | maxillary partial denture – resin base (including any conventional clasps, rests and teeth) | 480 | 425 | 150 | 108 |
| D5212 | mandibular partial denture – resin base (including any conventional clasps, rests and teeth) | 477 | 425 | 150 | 108 |
| D5213 | maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 681 | 650 | 330 | 108 |
| D5214 | mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 690 | 650 | 330 | 108 |
| D5225 | maxillary partial denture – flexible base (including any clasps, rests and teeth) | 480 | 500 | 360 | 108 |
| D5226 | mandibular partial denture – flexible base (including any clasps, rests and teeth) | 477 | 500 | 360 | 108 |
| D5282 | removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary | 496 | 475 | 275 | |
| D5283 | removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular | 496 | 475 | 275 | |
| D5410 | adjust complete denture – maxillary | 30 | 30 | 20 | |
| D5411 | adjust complete denture – mandibular | 30 | 30 | 20 | |
| D5421 | adjust partial denture – maxillary | 30 | 30 | 20 | |
| D5422 | adjust partial denture – mandibular | 30 | 30 | 20 | |
| D5511 | repair broken complete denture base, mandibular | 64 | 30 | 20 | |
| D5512 | repair broken complete denture base, maxillary | 64 | 30 | 20 | |
| D5520 | replace missing or broken teeth – complete denture (each tooth) | 54 | 40 | 20 | |
| D5611 | repair resin partial denture base, mandibular | 69 | 72 | 45 | |
| D5612 | repair resin partial denture base, maxillary | 69 | 72 | 45 | |
| D5621 | repair cast partial framework, mandibular | 63 | 54 | 35 | |
| D5622 | repair cast partial framework, maxillary | 63 | 54 | 35 | |
| D5630 | repair or replace broken clasp – per tooth | 77 | 65 | 40 | |
| D5640 | replace broken teeth – per tooth | 60 | 60 | 40 | |
| D5650 | add tooth to existing partial denture | 78 | 60 | 40 | |



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# AARP MEDICARE COMPLETE - SECURE HORIZONS DHMO (OVATIONS)
# PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
# EXHIBIT 2 - PART III

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| | SPECIALTY REFERRAL PROCESS ($1000 Calendar Year Maximum excluding Orthodontia): | NTCV | NTCV | PRE-AUTH | |
| 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 | | | |
| D5660 | add clasp to existing partial denture – per tooth | 90 | 70 | 40 | |
| D5670 | replace all teeth and acrylic on cast metal framework (maxillary) | 341 | 325 | 165 | |
| D5671 | replace all teeth and acrylic on cast metal framework (mandibular) | 345 | 325 | 165 | |
| D5730 | reline complete maxillary denture (chairside) | 111 | 95 | 60 | |
| D5731 | reline complete mandibular denture (chairside) | 108 | 95 | 60 | |
| D5740 | reline maxillary partial denture (chairside) | 89 | 95 | 60 | |
| D5741 | reline mandibular partial denture (chairside) | 105 | 95 | 60 | |
| D5750 | reline complete maxillary denture (laboratory) | 165 | 165 | 100 | |
| D5751 | reline complete mandibular denture (laboratory) | 158 | 165 | 100 | |
| D5760 | reline maxillary partial denture (laboratory) | 159 | 165 | 100 | |
| D5761 | reline mandibular partial denture (laboratory) | 162 | 165 | 100 | |
| D5850 | tissue conditioning, maxillary | NTCV | NTCV | 35 | |
| D5851 | tissue conditioning, mandibular | NTCV | NTCV | 35 | |
| D5863 | overdenture - complete maxillary | NTCV | 525 | 310 | |
| D5864 | overdenture - complete mandibular | NTCV | 480 | 310 | |
| D5865 | overdenture - partial maxillary | NTCV | 650 | 330 | |
| D5866 | overdenture - partial mandibular | NTCV | 650 | 330 | |
| **VII. MAXILLOFACIAL PROSTHETICS** | | | | | |
| • 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 | 450 | 275 | 48 |
| D6211 | pontic – cast predominantly base metal | 405 | 450 | 275 | 48 |
| D6212 | pontic – cast noble metal | 435 | 450 | 275 | 48 |
| D6214 | pontic – titanium | 405 | 450 | 275 | |
| D6240 | pontic – porcelain fused to high noble metal | 455 | 450 | 275 | 48 |
| D6241 | pontic – porcelain fused to predominantly base metal | 420 | 450 | 275 | 48 |
| D6242 | pontic – porcelain fused to noble metal | 441 | 450 | 275 | 48 |
| D6245 | pontic – porcelain/ceramic | 455 | 450 | 275 | 48 |
| D6250 | pontic – resin with high noble metal | 487 | 350 | 200 | 48 |
| D6251 | pontic – resin with predominantly base metal | 430 | 350 | 200 | 48 |
| D6252 | pontic – resin with noble metal | 430 | 350 | 200 | 48 |
| D6602 | retainer inlay – cast high noble metal, two surfaces | NTCV | NTCV | 200 | |
| D6603 | retainer inlay – cast high noble metal, three or more surfaces | NTCV | NTCV | 200 | |



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# AARP MEDICARE COMPLETE - SECURE HORIZONS DHMO (OVATIONS)
# PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
# EXHIBIT 2 - PART III

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| | SPECIALTY REFERRAL PROCESS ($1000 Calendar Year Maximum excluding Orthodontia): | NTCV | NTCV | PRE-AUTH | |
| | **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 | | | |
| D6604 | retainer inlay – cast predominantly base metal, two surfaces | NTCV | NTCV | 200 | |
| D6605 | retainer inlay – cast predominantly base metal, three or more surfaces | NTCV | NTCV | 200 | |
| D6606 | retainer inlay – cast noble metal, two surfaces | NTCV | NTCV | 200 | |
| D6607 | retainer inlay – cast noble metal, three or more surfaces | NTCV | NTCV | 200 | |
| D6624 | retainer inlay – titanium | NTCV | NTCV | 200 | |
| D6720 | retainer crown – resin with high noble metal | 434 | 350 | 200 | 48 |
| D6721 | retainer crown – resin with predominantly base metal | 434 | 350 | 200 | 48 |
| D6722 | retainer crown – resin with noble metal | 434 | 350 | 200 | 48 |
| D6740 | retainer crown – porcelain/ceramic | 487 | 500 | 250 | 48 |
| D6750 | retainer crown – porcelain fused to high noble metal | 456 | 450 | 275 | 48 |
| D6751 | retainer crown – porcelain fused to predominantly base metal | 438 | 450 | 275 | 48 |
| D6752 | retainer crown – porcelain fused to noble metal | 455 | 454 | 275 | 48 |
| D6780 | retainer crown – ¾ cast high noble metal | 438 | 460 | 275 | 48 |
| D6781 | retainer crown – ¾ cast predominantly base metal | 459 | 460 | 275 | 48 |
| D6782 | retainer crown – ¾ cast noble metal | 459 | 460 | 275 | 48 |
| D6783 | retainer crown – ¾ porcelain/ceramic | 459 | 500 | 250 | 48 |
| D6790 | retainer crown – full cast high noble metal | 455 | 450 | 200 | 48 |
| D6791 | retainer crown – full cast predominantly base metal | 428 | 455 | 200 | 48 |
| D6792 | retainer crown – full cast noble metal | 438 | 450 | 200 | 48 |
| D6794 | retainer crown – titanium | 428 | 450 | 275 | 48 |
| D6930 | re-cement or re-bond fixed partial denture | 43 | 40 | 30 | |
| **X. ORAL AND MAXILLOFACIAL SURGERY** | | | | | |
| | **• Includes local anesthesia, suturing, and routine post-operative care.** | | | | |
| D7111 | extraction, coronal remnants – primary tooth | 51 | 45 | 25 | |
| D7140 | extraction, erupted tooth or exposed root (elevation and/or forceps removal) | 54 | 45 | 25 | |
| D7210 | extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | NTCV | NTCV | 50 | |
| D7220 | removal of impacted tooth – soft tissue | NTCV | NTCV | 100 | |
| D7230 | removal of impacted tooth – partially bony | NTCV | NTCV | 135 | |
| D7240 | removal of impacted tooth – completely bony | NTCV | NTCV | 170 | |
| D7250 | removal of residual tooth roots (cutting procedure) | NTCV | NTCV | 90 | |
| D7285 | incisional biopsy of oral tissue – hard (bone, tooth) | NTCV | NTCV | 100 | |



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# AARP MEDICARE COMPLETE - SECURE HORIZONS DHMO (OVATIONS)
# PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
# EXHIBIT 2 - PART III

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|---|---|---|---|---|---|---|
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| | SPECIALTY REFERRAL PROCESS ($1000 Calendar Year Maximum excluding Orthodontia): | | NTCV | NTCV | PRE-AUTH | |
| 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 | | | |
| D7286 | incisional biopsy of oral tissue – soft | | NTCV | NTCV | 100 | |
| D7310 | alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | | NTCV | NTCV | 100 | |
| D7311 | alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | | NTCV | NTCV | 80 | |
| D7320 | alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | | NTCV | NTCV | 150 | |
| D7321 | alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | | NTCV | NTCV | 75 | |
| D7471 | removal of lateral exostosis (maxilla or mandible) | | NTCV | NTCV | 150 | |
| D7472 | removal of torus palatinus | | NTCV | NTCV | 150 | |
| D7473 | removal of torus mandibularis | | NTCV | NTCV | 150 | |
| D7485 | reduction of osseous tuberosity | | NTCV | NTCV | 150 | |
| D7510 | incision and drainage of abscess – intraoral soft tissue | | 65 | 65 | 35 | |
| D7511 | incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | | 98 | 80 | 50 | |
| D7520 | incision and drainage of abscess – extraoral soft tissue | | NTCV | NTCV | 50 | |
| D7521 | incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | | NTCV | NTCV | 60 | |
| **XII. ADJUNCTIVE GENERAL SERVICES** | | | | | | |
| D9110 | palliative (emergency) treatment of dental pain – minor procedure | | 38 | 40 | 0 | |
| D9215 | local anesthesia in conjunction with operative or surgical procedures | | 0 | 0 | 0 | |
| D9310 | consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician | | NTCV | NTCV | 50 | |
| D9430 | office visit for observation (during regularly scheduled hours) – no other services performed | | 5 | 5 | 5 | |
| D9440 | office visit – after regularly scheduled hours | | 50 | 50 | 30 | |
| D9450 | case presentation, detailed and extensive treatment planning | | NTCV | 50 | 30 | |
| D9951 | occlusal adjustment – limited | | 35 | 30 | 15 | |



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# AARP MEDICARE COMPLETE - SECURE HORIZONS DHMO (OVATIONS)
# PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
# EXHIBIT 2 - PART III

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| | SPECIALTY REFERRAL PROCESS ($1000 Calendar Year Maximum excluding Orthodontia): | | NTCV | NTCV | PRE-AUTH | |
| 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 | | | |
| **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.





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# AARP MEDICARE COMPLETE - SECURE HORIZONS DHMO (OVATIONS)
# LIMITATION AND EXCLUSIONS OF BENEFITS
# EXHIBIT 2

## 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 appoitnment.
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).
   g) 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

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

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 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
3) 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 determined by your assigned dentist.
4) 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 listed Copayment, but instead can reflect the Dentist's Billed Charges.
5) 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

8. **OCCLUSAL 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**

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.
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.

**UNITEDHEALTHCARE EHB DHMO PLANS**
**PRINCIPAL BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART IV**

| Customer Service Phone Number 1-877-732-4337 | | 2018 / 2019 UHC CA EHB | |
|---|---|---|---|
| Specialty Referral Process: (All medically necessary orthodontic treatment requests and specialty referrals must be pre-authorized) | | Pre-Authorization Required | |
| Agreement ID: | | 2019 EHB DHMO: SCFG00000698 | |
| Agreement ID: | | 2018 EHB DHMO: SCFG00000263 | |
| CDT Code | | Member Copayment | Minimum Guarantee |
| ***† 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.*** | | | |
| **I. DIAGNOSTIC** | | | |
| 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 | |



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| D0502 | other oral pathology procedures, by report | 0 | |
| 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 |
| **II. PREVENTIVE** | | | |
| 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 ***(Benefit under 2019 EHB plan only)*** | 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 | |
| **III. RESTORATIVE** | | | |
| D2140 | amalgam – one surface, primary or permanent | 25 | |
| D2150 | amalgam – two surfaces, primary or permanent | 30 | |
| D2160 | amalgam – three surfaces, primary or permanent | 40 | |



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| 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 | |
| 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 |



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| CDT Code | | Member Copayment | Minimum Guarantee |
| 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 | |
| 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 | |
| **IV. ENDODONTICS** | | | |
| 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 | |



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| CDT Code | | Member Copayment | Minimum Guarantee |
| 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 | |
| **V. PERIODONTICS** | | | |
| 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 | |
| **VI. PROSTHODONTICS, REMOVABLE** | | | |
| 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 |



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| CDT Code | | Member Copayment | Minimum Guarantee |
| 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 | |
| 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 | |



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| 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 | |
| D5899 | unspecified removable prosthodontic procedure, by report | 350 | |
| **VII. MAXILLOFACIAL PROSTHETICS - COVERED ONLY WHEN MEDICALLY NECESSARY** | | | |
| 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 | |



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| CDT Code | | Member Copayment | Minimum Guarantee |
| 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 | |
| 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 | |
| **VIII. IMPLANT SERVICES** | | | |
| 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: eposteal 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 |



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|---|---|---|---|
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| CDT Code | | Member Copayment | Minimum Guarantee |
| 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 |
| 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 |



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| 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 | |
| **IX. PROSTHODONTICS, FIXED** | | | |
| 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 | |
| **X. ORAL & MAXILLOFACIAL SURGERY** | | | |
| 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 | |



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| CDT Code | | Member Copayment | Minimum Guarantee |
| 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 | |
| D7291 | transseptal 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 | |



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| CDT Code | | Member Copayment | Minimum Guarantee |
| 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 | |
| D7550 | partial ostectomy/sequestrectomy for removal of non-vital bone | 125 | |
| D7560 | maxillary sinusotomy for removal of tooth fragment or foreign body | 235 | |
| • 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. Covered Only when Medically Necessary. | | | |
| 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 | |



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| 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 | |
| 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 | |



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| 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 | |
| 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 | |
| **XII. ADJUNCTIVE GENERAL SERVICES** | | | |
| 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 | |



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| 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/anxiolysis, 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 | |
| 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 | |



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| **XI. ORTHODONTICS (ONLY MEDICALLY NECESSARY TREATMENT IS COVERED)** | | | |
| **• 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<br><br>2019 EHB 350 | |
| 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 | | |
| 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 | | |





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# UNITEDHEALTHCARE EHB DHMO
# LIMITATIONS AND EXCLUSIONS
# EXHIBIT 2

## 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).
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).
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.
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
- 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

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|---|---|---|---|---|---|---|---|
| | | | SFSGD0000008 | SFSGD0000013 | SFSGD0000014 | SFSGD0000007 | SFSGD0000016 |
| | | | Member Copayment | | | | |
| | SPECIALTY REFERRAL BENEFITS (*$1000 Calendar Year Maximum): | | Ortho Only | YES* | YES | YES | YES |
| | SUPPLEMENTAL REIMBURSEMENT: | | NO | YES | YES | YES | YES |
| **I. DIAGNOSTIC** | | | | | | | |
| 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 |



NTCV = Not a Covered Benefit

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| 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 | | | | |
| **II. PREVENTIVE** | | | | | | | |
| 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 |
| **III. RESTORATIVE** | | | | | | | |
| | *** 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 |



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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 | | 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 – ¾ 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 – ¾ cast high noble metal | 48 | 204* | 120* | 250* | 175* | 175* |
| D2781 | crown – ¾ cast predominantly base metal | 48 | 204 | 120 | 250 | 175 | 175 |
| D2782 | crown – ¾ cast noble metal | 48 | 204* | 120* | 250* | 175* | 175* |
| D2783 | crown – ¾ 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 |



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|---|---|---|---|---|---|---|---|
| | | | SFSGD0000008 | SFSGD0000013 | SFSGD0000014 | SFSGD0000007 | SFSGD0000016 |
| | | | Member Copayment | | | | |
| D2931 | prefabricated stainless steel crown – permanent tooth | | 55 | 17 | 25 | 25 | 25 |
| D2932 | prefabricated resin crown | | 55 | 17 | 25 | 25 | 25 |
| 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 |
| **IV. ENDODONTICS** | | | | | | | |
| 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 |



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|---|---|---|---|---|---|---|---|
| | | | SFSGD0000008 | SFSGD0000013 | SFSGD0000014 | SFSGD0000007 | SFSGD0000016 |
| | | | Member Copayment | | | | |
| D3427 | periradicular surgery without apicoectomy | | NTCV | NTCV | NTCV | NTCV | NTCV |
| D3430 | retrograde filling – per root | | NTCV | 0 | NTCV | NTCV | NTCV |
| 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 |
| **V. PERIODONTICS** | | | | | | | |
| 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 staff) | | 0 | 0 | 0 | 0 | 0 |
| D4921 | gingival irrigation - per quadrant | | 0 | 0 | 3 | 0 | 0 |
| **VI. PROSTHODONTICS, REMOVABLE** *Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade.** | | | | | | | |
| D5110 | complete denture – maxillary | 108 | 308 | 160 | 300 | 195 | 195 |
| D5120 | complete denture – mandibular | 108 | 308 | 160 | 300 | 195 | 195 |



NTCV = Not a Covered Benefit

## UNITEDHEALTHCARE / PACIFICARE DHMO
## PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
## EXHIBIT 2 - PART V

| CDT Code | Plan Name / Copayment Schedule / Agreement ID: | Supplemental Payment | DENTAL 100 SFSGD0000008 | DENTAL 132 SFSGD0000013 | DENTAL 140 SFSGD0000014 | DENTAL 142 SFSGD0000007 | DENTAL 142 FEDS SFSGD0000016 |
|---|---|---|---|---|---|---|---|
| | | | Member Copayment | | | | |
| D5130 | immediate denture – maxillary | 108 | 308 | 160 | 300 | 195 | 195 |
| D5140 | immediate denture – mandibular | 108 | 308 | 160 | 300 | 195 | 195 |
| 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 |



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**UNITEDHEALTHCARE / PACIFICARE DHMO**
**PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS**
**EXHIBIT 2 - PART V**

| CDT Code | Plan Name / Copayment Schedule / Agreement ID: | Supplemental Payment | DENTAL 100 SFSGD0000008 | DENTAL 132 SFSGD0000013 | DENTAL 140 SFSGD0000014 | DENTAL 142 SFSGD0000007 | DENTAL 142 FEDS SFSGD0000016 |
|---|---|---|---|---|---|---|---|
| | | | Member Copayment | | | | |
| 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 |
| 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 |



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## EXHIBIT 2 - PART V

| CDT Code | Plan Name / Copayment Schedule / Agreement ID: | Supplemental Payment | DENTAL 100 SFSGD0000008 | DENTAL 132 SFSGD0000013 | DENTAL 140 SFSGD0000014 | DENTAL 142 SFSGD0000007 | DENTAL 142 FEDS SFSGD0000016 |
|---|---|---|---|---|---|---|---|
| | | | Member Copayment | | | | |
| 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* |
| 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 |



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# UNITEDHEALTHCARE / PACIFICARE DHMO
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# 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 | | | | |
| **VIII. ORAL & MAXILLOFACIAL SURGERY** | | | | | | | |
| 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 |
| 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 |



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| 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 | | | | |
| D7972 | surgical reduction of fibrous tuberosity | | NTCV | 100 | 100 | 100 | 100 |
| **IX. ADJUNCTIVE GENERAL SERVICES** | | | | | | | |
| D9110 | palliative (emergency) treatment of dental pain – minor procedure | | 20 | 5 | 10 | 5 | 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 | | 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.***





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# 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 | | | | |
| | SPECIALTY REFERRAL BENEFITS (*$1000 Calendar Year Maximum): | | YES | YES | Ortho Only | YES* | YES* |
| | SUPPLEMENTAL REIMBURSEMENT APPLIES: | | YES | YES | NO | NO | NO |
| **I. DIAGNOSTIC** | | | | | | | |
| 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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# 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 | | | | |
| **II. PREVENTIVE** | | | | | | | |
| 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 |
| **III. RESTORATIVE** | | | | | | | |
| *** 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 |
| D2394 | resin-based composite – four or more surfaces, posterior | | 117 | 117 | 117 | 117 | 117 |



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## 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 | | | | |
| 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 |



NTCV = Not a Covered Benefit

## UNITEDHEALTHCARE / PACIFICARE DHMO
## PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
## 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 | | | | |
| 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 |
| **IV. ENDODONTICS** | | | | | | | |
| 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 |
| D3910 | surgical procedure for isolation of tooth with rubber dam | | 0 | 0 | NTCV | NTCV | NTCV |



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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 |
| | | | Member Copayment | | | | |
| D3950 | canal preparation and fitting of preformed dowel or post | | 0 | 0 | 0 | 0 | 0 |
| **V. PERIODONTICS** | | | | | | | |
| 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 |
| **VI. PROSTHODONTICS, REMOVABLE** *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 |
| D5211 | maxillary partial denture – resin base (including any conventional clasps, rests and teeth) | 108 | 100 | 90 | 225 | 225 | 150 |



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|---|---|---|---|---|---|---|---|
| | | | SFSGD0000003 | SFSGD0000018 | SFSGD0000019 | SFSGD0000020 | SFSGD0000015 |
| | | | Member Copayment | | | | |
| 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* |
| 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 |



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## UNITEDHEALTHCARE / PACIFICARE DHMO
## PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
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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 |
| | | | Member Copayment | | | | |
| 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 |
| **IX. 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 | 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* |
| 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 |



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# UNITEDHEALTHCARE / PACIFICARE DHMO
# PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
# 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 | | | | |
| 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 |
| **X. ORAL & MAXILLOFACIAL SURGERY** | | | | | | | |
| 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 |
| 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 |



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|---|---|---|---|---|---|---|---|
| | | | SFSGD0000003 | SFSGD0000018 | SFSGD0000019 | SFSGD0000020 | SFSGD0000015 |
| | | | Member Copayment | | | | |
| 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 |
| **XII. ADJUNCTIVE GENERAL SERVICES** | | | | | | | |
| 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 |
| D9223 | deep sedation/general anesthesia – each subsequent 15 minute increment | | 45 | 45 | 60 | 60 | 45 |
| D9230 | inhalation of nitrous oxide/anxiolysis, analgesia | | NTCV | NTCV | NTCV | NTCV | 30 |
| D9239 | intravenous moderate (conscious) sedation/anesthesia – first 15 minutes | | 175 | 175 | 175 | 175 | 175 |



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## UNITEDHEALTHCARE / PACIFICARE DHMO
## PRINCIPLE BENEFITS AND COVERAGES - MEMBER COPAYMENTS
## EXHIBIT 2 - PART VI

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|---|---|---|---|---|---|---|---|
| | | | SFSGD0000003 | SFSGD0000018 | SFSGD0000019 | SFSGD0000020 | SFSGD0000015 |
| | | | Member Copayment | | | | |
| 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.***





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# UNITEDHEALTHCARE / PACIFICARE DHMO
# EXCLUSIONS AND LIMITATIONS
# EXHIBIT 2

## 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. **OCCLUSAL 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 myofacial 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: | UnitedHealthcare |
|---|---|---|
| Treatment Plan No.: | | Chart ID No.: |

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

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

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

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

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

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

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

| | | | | 1 | 2 | 3 |
|---|---|---|---|---|---|---|
| CDT Code of Proposed Treatment | Proposed Procedure Description | Tooth No. or Area | UCR Fee of Proposed Treatment | Copayment of Benefit | Additional Charge for Metal Upgrade | Accepted Charge |
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*Reason for Upgrade / Reason proposed service is not covered:

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

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