DIRECT REFERRAL DENTAL PLAN
HN VALUE DHMO 115
SCHEDULE OF BENEFITS

Benefits provided by Dental Benefit Providers of California, Inc.

This document describes the Covered Services of this Health Net of California dental plan, as well as Co-payment requirements, Limitations of Benefits and Exclusions. Covered Services are also subject to the terms and conditions stated in the Evidence of Coverage and the Group Agreement.

Except for Emergency Dental Care as described in the Evidence of Coverage and Orthodontia as described below, all of the following services must be provided by the Member's Primary Dentist in order to be Covered Services under this dental plan unless prior approval is obtained for referral to a specialist. For more information, visit www.healthnet.com

Code	Service	Member Co-payment
Diagnostic		
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0170	Re-evaluation - limited, problem focused, (established patient; non-post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Intraoral - complete series (including bitewings)	$0
D0220	Intraoral - periapical first film	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal film	$0
D0250	Extraoral - first film	$0
D0260	Extraoral - each additional film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings - 7 to 8 films	$0
D0330	Panoramic film	$0
D0350	Oral/facial photographic images	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$15
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
Preventive		
D1110	Prophylaxis - adult	$0
D1110	Prophylaxis - adult (in addition to one allowed every six months)	$40
D1120	Prophylaxis - child	$0
D1120	Prophylaxis - child (in addition to one allowed every six months)	$25
D1201	Topical application of fluoride (including prophylaxis) - child	$0
D1203	Topical application of fluoride (prophylaxis not included) - child	$0
D1204	Topical application of fluoride (prophylaxis not included) - adult	$0

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D1205	Topical application of fluoride (including prophylaxis) - adult	$0
D1310	Nutritional counseling for control of dental disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$5
D1510	Space maintainer - fixed - unilateral	$20
D1515	Space maintainer - fixed - bilateral	$20
D1520	Space maintainer - removable - unilateral	$20
D1525	Space maintainer - removable - bilateral	$20
D1550	Re-cementation of space maintainer	$5

Restorative

D2140	Amalgam - one surface, primary or permanent	$0
D2150	Amalgam - two surfaces, primary or permanent	$0
D2160	Amalgam - three surfaces, primary or permanent	$0
D2161	Amalgam - four or more surfaces, primary or permanent	$0
D2330	Resin-based composite - one surface, anterior	$0
D2331	Resin-based composite - two surfaces, anterior	$0
D2332	Resin-based composite - three surfaces, anterior	$0
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$0
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite - one surface, posterior - primary	$15
D2392	Resin-based composite - two surfaces, posterior - primary	$20
D2393	Resin-based composite - three surfaces, posterior - primary	$30
D2394	Resin-based composite - four or more surfaces, posterior - primary	$30
D2391	Resin-based composite - one surface, posterior	$65
D2392	Resin-based composite - two surfaces, posterior	$75
D2393	Resin-based composite - three surfaces, posterior	$80
D2394	Resin-based composite - four or more surfaces, posterior	$80
D2510	Inlay - metallic - one surface*.	$115
D2520	Inlay - metallic - two surfaces*	$115
D2530	Inlay - metallic - three or more surfaces*	$115
D2542	Onlay - metallic - two surfaces*	$115
D2543	Onlay - metallic - three surfaces*	$115
D2544	Onlay - metallic - four or more surfaces*	$115

Crowns - Single Restorations Only

D2740	Crown - porcelain/ceramic substrate	$225
D2740	Crown - porcelain/ceramic substrate (Leucite-reinforced pressed crown/Empress)	Co-payment + $300
D2750	Crown - porcelain fused to high noble metal*	$115
D2750	Crown - porcelain fused to high noble metal (gold composite reinforced crown/Captek)	Co-payment + $300
D2751	Crown - porcelain fused to predominantly base metal	$115
D2752	Crown - porcelain fused to noble metal*	$115
D2780	Crown - 3/4 cast high noble metal*	$115
D2781	Crown - 3/4 cast predominantly base metal	$115
D2782	Crown - 3/4 cast noble metal*	$115
D2783	Crown - 3/4 porcelain/ceramic	$115
D2790	Crown - full cast high noble metal*	$115
D2791	Crown - full cast predominantly base metal	$115
D2792	Crown - full cast noble metal*	$115
D2794	Crown - titanium	$115
D2910	Recement inlay, onlay, or partial coverage restoration	$0
D2915	Recement cast or prefabricated post and core	$0

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D2920	Recement crown	$0
D2930	Prefabricated stainless steel crown - primary tooth	$0
D2931	Prefabricated stainless steel crown - permanent tooth	$0
D2940	Sedative filling	$0
D2950	Core buildup, including any pins*	$15
D2951	Pin retention - per tooth, in addition to restoration*	$10
D2952	Cast post and core in addition to crown*	$25
D2953	Each additional cast post - same tooth*	$25
D2954	Prefabricated post and core in addition to crown	$25
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2970	Temporary crown (fractured tooth)	$0

Endodontics

D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$0
D3221	Pulpal debridement, primary and permanent teeth	$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$5
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$10
D3310	Anterior (excluding final restoration)	$70
D3320	Bicuspid (excluding final restoration)	$80
D3330	Molar (excluding final restoration)	$150
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70
D3346	Retreatment of previous root canal therapy - anterior	$80
D3347	Retreatment of previous root canal therapy- bicuspid	$100
D3348	Retreatment of previous root canaltherapy - molar	$200
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption,etc.)	$65
D3410	Apicoectomy/periradicular surgery - anterior	$90
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$90
D3425	Apicoectomy/periradicular surgery - molar (first root)	$100
D3426	Apicoectomy/periradicular surgery - (each additional root)	$90
D3430	Retrograde filling - per root	$90
D3450	Root amputation - per root	$95
D3920	Hemisection (including any root removal), not including root canal therapy	$90

Periodontics

D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces - per quadrant	$35
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces - per quadrant	$35
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	$150
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces - per quadrant	$150
D4249	Clinical crown lengthening - hard tissue	$125
D4260	Osseous surgery (including flap entry and closure) - four or more	

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	contiguous teeth or bounded teeth spaces - per quadrant	$275
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces - per quadrant	$275
D4270	Pedicle soft tissue graft procedure	$300
D4271	Free soft tissue graft (including donor site surgery)	$300
D4273	Subepithelial connective tissue graft procedures	$300
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$50
D4341	Periodontal scaling and root planing - four or more teeth – per quadrant	$25
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$25
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$15
D4381	Localized delivery of chemotherapeutic agent via controlled release vehicle into diseased crevicular tissue, per tooth, by report	$60
D4910	Periodontal maintenance	$15
D4999	Periodontal charting for treatment planning of periodontal disease	$0

Prosthodontics (Removable)

D5110	Complete denture - maxillary	$125
D5110	Complete denture - maxillary (Comfort Flex (complete upper denture) acetyle resin homopolymer)	Co-payment + $400
D5120	Complete denture -mandibular	$125
D5120	Complete denture -mandibular (Comfort Flex (complete lower denture) acetyle resin homopolymer)	Co-payment + $400
D5130	Immediate denture - maxillary	$125
D5130	Immediate denture - maxillary (Comfort Flex (complete upper denture) acetyle resin homopolymer)	Co-payment + $400
D5140	Immediate denture -mandibular	$125
D5140	Immediate denture -mandibular (Comfort Flex (complete lower denture) acetyle resin homopolymer)	Co-payment + $400
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	$150
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth) (Comfort Flex (upper partial denture) acetyle resin homopolymer)	Co-payment + $425
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	$150
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth) (Comfort Flex (lower partial denture) acetyle resin homopolymer)	Co-payment + $425
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$175
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (Comfort Flex (upper partial denture) acetyle resin homopolymer)	Co-payment + $425
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$ 175
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (Comfort Flex (lower partial denture) acetyle resin homopolymer)	Co-payment + $425
D5410	Adjust complete denture - maxillary	$10
D5411	Adjust complete denture - mandibular	$10
D5421	Adjust partial denture - maxillary	$10
D5422	Adjust partial denture - mandibular	$10
D5510	Repair broken complete denture base	$15

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D5520	Replace missing or broken tooth - complete denture (each tooth)	$15
D5610	Repair resin denture base	$15
D5620	Repair cast framework	$15
D5630	Repair or replace broken clasp	$15
D5640	Replace broken teeth - per tooth	$15
D5650	Add tooth to existing partial denture	$15
D5660	Add clasp to existing partial denture	$15
D5710	Rebase complete maxillary denture	$50
D5711	Rebase complete mandibular denture	$50
D5720	Rebase maxillary partial denture	$50
D5721	Rebase mandibular partial denture	$50
D5730	Reline complete maxillary denture (chairside)	$25
D5731	Reline complete mandibular denture (chairside)	$25
D5740	Reline maxillary partial denture (chairside)	$25
D5741	Reline mandibular partial denture (chairside)	$25
D5750	Reline complete maxillary denture (laboratory)	$50
D5751	Reline complete mandibular denture (laboratory)	$50
D5760	Reline maxillary partial denture (laboratory)	$50
D5761	Reline mandibular partial denture (laboratory)	$50
D5810	Interim complete denture (maxillary)	$60
D5811	Interim complete denture (mandibular)	$60
D5820	Interim partial denture (maxillary)	$40
D5821	Interim partial denture (mandibular)	$40
D5850	Tissue conditioning, maxillary	$10
D5851	Tissue conditioning, mandibular	$10

Prosthodontics (Fixed)

D6210	Pontic - cast high noble metal*	$115
D6211	Pontic - cast predominantly base metal	$115
D6212	Pontic - cast noble metal*	$115
D6214	Pontic - titanium	$115
D6240	Pontic - porcelain fused to high noble metal*	$115
D6240	Pontic - porcelain fused to high noble metal (gold composite reinforced crown/Captek)	Co-payment + $300
D6241	Pontic - porcelain fused to predominantly base metal*	$115
D6242	Pontic - porcelain fused to noble metal*	$115
D6245	Pontic - porcelain / ceramic	$115
D6245	Pontic - porcelain / ceramic (Leucite-reinforced pressed crown/ Empress)	Co-payment + $300
D6740	Crown - porcelain / ceramic	$225
D6740	Crown - porcelain / ceramic (Leucite-reinforced pressed crown/ Empress)	Co-payment + $300
D6750	Crown - porcelain fused to high noble metal*	$115
D6750	Crown - porcelain fused to high noble metal (Gold composite reinforced crown/Captek)	Co-payment + $300
D6751	Crown - porcelain fused to predominantly base metal*	$115
D6752	Crown - porcelain fused to noble metal*	$115
D6780	Crown - 3/4 cast high noble metal*	$115
D6781	Crown - 3/4 cast predominantly base metal	$115
D6782	Crown - 3/4 cast noble metal*	$115
D6790	Crown - full cast high noble metal*	$115
D6791	Crown - full cast predominantly base metal*	$115
D6792	Crown - full cast noble metal*	$115
D6794	Crown - titanium	$115

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D6930	Recement fixed partial denture	$0
D6970	Cast post and core addition to fixed partial denture retainer*	$25
D6971	Cast post as part of fixed partial denture retainer*	$25
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$25
D6973	Core build up for retainer, including any pins*	$15
D6976	Each additional cast post - same tooth*	$25
D6977	Each additional prefabricated post - same tooth	$15

Oral and Maxillofacial Surgery

D7111	Extraction, coronal remnants - deciduous tooth	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (extraction - each additional tooth)	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (root removal - exposed roots)	$0
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$20
D7220	Removal of impacted tooth - soft tissue	$35
D7230	Removal of impacted tooth - partially bony	$65
D7240	Removal of impacted tooth - completely bony	$95
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$130
D7250	Surgical removal of residual tooth roots (cutting procedure)	$50
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110
D7280	Surgical access exposure of an unerupted tooth	$175
D7285	Biopsy of oral tissue - hard (bone,tooth)	$15
D7286	Biopsy of oral tissue - soft (all others)	$25
D7310	Alveoplasty in conjunction with extractions, per quadrant	$20
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$7
D7320	Alveoplasty not in conjunction with extractions, per quadrant	$40
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$14
D7510	Incision and drainage of abscess - intraoral soft tissue	$0
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$0
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$10
D7963	Frenuloplasty	$10
D7971	Excision of pericoronal gingiva	$40

Orthodontics

D8050	Removable and/or Fixed Appliance(s) Insertion for Interceptive Treatment, primary dentition	$725
D8060	Removable and/or Fixed Appliance(s) Insertion for Interceptive Treatment, transitional dentition	$725
D8070	Comprehensive orthodontic treatment transitional dentition	$1,950
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,950
D8090	Comprehensive orthodontic treatment of the adult dentintion	$2,250
D8660	Pre-orthodontic treatment visit	$0
D8670	Periodontic orthodontic treatment visit (as part of contract)	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer (s))	$250

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D8999	Start-up fee (including exam, beginning records, x-rays, tracings, photos and models)	$250
D8999	Post-treatment records	$150
D8999	Monthly orthodontic fee (for comprehensive treatment beyond 24 months)	$35

Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9215	Local anesthesia	$0
D9220	Deep sedation/general anesthesia - first 30 minutes	$125
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$60
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$125
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$60
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$0
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$20
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard, by report	$100
D9942	Repair and/or reline of occlusal guard	$50
D9951	Occlusal adjustment - limited	$0
D9952	Occlusal adjustment - complete	$0
D9999	Record transfer - transfer of all materials with or without an x-ray	$15

Materials Upgrades for Non-Elective Dental Services (in addition to co-payment for service)

D2750	Porcelain on molar crowns	$75
D2999	Semi or precious metal for crowns	lab cost
D2740	Leucite-reinforced pressed crown/Empress	$300 + co-payment
D2750	Gold composite reinforced crown/Captek	$300 + co-payment
D5110	Comfort Flex Complete Upper Denture/acetyle resin homopolymer	$400 + co-payment
D5120	Comfort Flex Complete Lower Denture/acetyle resin homopolymer	$400 + co-payment
D5211	Comfort Flex Upper Partial Denture/acetyle resin homopolymer	$425 + co-payment
D5212	Comfort Flex Lower Partial Denture/acetyle resin homopolymer	$425 + co-payment

Cosmetic Dentistry Services (Elective Services)

D2330	Resin based-composite - one surface, anterior	$80
D2331	Resin based-composite - two surfaces, anterior	$95
D2332	Resin based-composite - three surfaces, anterior	$105
D2335	Resin based-composite, four or more surfaces or involving incisal angle (anterior)	$125
D2391	Resin based-composite - one surface, posterior	$85
D2392	Resin based-composite - two surfaces, posterior	$100
D2393	Resin based-composite - three surfaces, posterior	$110
D2394	Resin based-composite - four or more surfaces, posterior	$130
D2740	Leucite-reinforced pressed crown/Empress	$700
D2750	Cosmetic crown-porcelain fused to predominately base/noble/ high noble crown	$500
D2962	Labial veneer/porcelain laminate	$450
D5110	Comfort Flex (complete upper denture) acetyle resin homopolymer	$650
D5120	Comfort Flex (complete lower denture) acetyle resin homopolymer	$650
D5211	Comfort Flex (upper partial denture) acetyle resin homopolymer	$725

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D5212	Comfort Flex (lower partial denture) acetyle resin homopolymer	$725
D9972	External bleaching - per arch	$125

Exclusions and Limitations

Limitations of Benefits

Listed below are limitations on services covered under the plan.

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

Exclusions

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

1. Services not listed on the Schedule of Benefits.
2. Services provided by a non-participating provider without prior approval, except in emergencies.
3. Services related to any injury or illness covered under Workers' Compensation, occupational disease or similar laws.
4. Services provided or paid through a federal or state government agency or authority, political subdivision or public program other than Medicaid.
5. Services relating to injuries which are intentionally self-inflicted.
6. Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared act of war.
7. Cosmetic dentistry unless specifically listed as a covered benefit.
8. Prescription drugs.
9. Procedures, appliances or restorations if the purpose is to, a) change vertical dimension, or b) diagnose or treat abnormal conditions of the temporomandibular joint.
10. The completion of crown and bridge, dentures, root canal treatment, and orthodontics already in progress on the date the member becomes eligible under the plan.
11. Services associated with the placement or prosthodontic restoration of a dental implant.
12. Services considered to be unnecessary or experimental in nature.
13. Procedures or appliances for minor tooth guidance or to control harmful habits.

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14. Hospitalization, including any associated incremental charges for dental services performed in a hospital.
15. Services to the extent the member is compensated for them under any group medical plan, no fault insurance policy or insured.
16. Crowns and bridges used solely for splinting.
17. Resin bonded retainers and associated pontics.

Orthodontic Benefit Limitations & Exclusions

1. Orthodontic benefits are available only at Participating Orthodontic offices.
2. If the Member relocates to an area and is unable to receive treatment with the original Participating Orthodontist, coverage under this program ceases and it becomes the obligation of the Member to pay the Usual and Customary Fee of the orthodontist where the treatment is completed.
3. Covered treatment cannot be transferred by the Member from one Participating Orthodontist to another Participating Orthodontist.
4. No benefit will be paid for an orthodontic treatment program that began before the Member enrolled in the Orthodontic Plan.
5. If the Member becomes ineligible during the course of treatment, coverage under this program ceases and it becomes the obligation of the Member to pay the Usual and Customary Fees incurred for the entire remaining balance of treatment.
6. Orthognathic surgery cases and cases involving cleft palate, micrognathia, macroglossia, hormonal imbalances, temporomandibular joint disorders (T.M.J.), or myofunctional therapy are excluded.
7. Re-treatment of orthodontic cases, changes in treatment necessitated by an accident of any kind, and treatment due to neglect or non-cooperation are excluded.
8. The following are not included in the orthodontic benefits and the orthodontist's Usual and Customary charges apply:
    - Lingual or clear brackets
    - Replacement of lost or broken appliances, bands, brackets or orthodontic retainers.

If there are any conflicts in the provisions of the Evidence of Coverage and this Schedule of Benefits, the provisions of the Evidence of Coverage shall govern.

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