Platinum 90 Ambetter HMO (Plan KNW)

SCHEDULE OF BENEFITS AND COPAYMENTS

The following schedule shows the Copayments (fixed dollar and percentage amounts) that you must pay for this Plan's Covered Services and supplies.

You must pay the stated fixed dollar Copayments at the time you receive services. Percentage Copayments are usually billed after services are received.

There is a limit to the amount of Copayments you must pay in a Calendar Year. Refer to the "Out-of-Pocket Maximum" section for more information.

Covered Services for medical conditions and Mental Health and Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Services delivered in-person. Please refer to the "Telehealth Services" definition in the "Definitions" section for more information.

Emergency or Urgently Needed Care in an Emergency Room or Urgent Care Center (Medical care other than Mental Health and Substance Use Disorders)

	Copayment
Use of emergency room facility	$150
Emergency room Physician	$0
Use of urgent care center (facility and professional services)	$15

Copayment Exception(s):

- If you are admitted to a Hospital as an inpatient directly from the emergency room, the emergency room facility Copayment will not apply.
- If you receive care from an urgent care center owned and operated by your Physician Group, the urgent care Copayment will not apply. (But a visit to one of its facilities will be considered an office visit, and any Copayment required for office visits will apply.)
- For Emergency Care in an emergency room or urgent care center, you are required to pay only the Copayment amounts required under this Plan as described above. Refer to "Ambulance Services" below for emergency medical transportation Copayment.

Emergency or Urgently Needed Care in an Emergency Room or Urgent Care Center (Mental Health and Substance Use Disorders)

	Copayment
Use of emergency room facility	$150
Emergency room Physician	$0
Use of urgent care center (facility and professional services)	$15

Copayment Exception(s):

- If you are admitted to a Hospital as an inpatient directly from the emergency room, the emergency room facility Copayment will not apply.
- If you receive care from an urgent care center owned and operated by your Physician Group, the urgent care Copayment will not apply. (But a visit to one of its facilities will be considered an office visit, and any Copayment required for office visits will apply.)
- For Emergency Care in an emergency room or urgent care center, you are required to pay only the Copayment amounts required under this Plan as described above. Refer to "Ambulance Services" below for emergency medical transportation Copayment.

Ambulance Services (Medical care other than Mental Health and Substance Use Disorders)

	Copayment
Ground ambulance	$150
Air ambulance	$150

Note(s):

- For more information on ambulance services coverage, refer to the "Ambulance Services" portions of the "Covered Services and Supplies" section, and the "Exclusions and Limitations" section.

Ambulance Services (Mental Health and Substance Use Disorders)

	Copayment
Ground ambulance	$150
Air ambulance	$150

Note(s):

- For more information on ambulance services coverage, refer to the "Ambulance Services" portions of the "Covered Services and Supplies" section, and the "Exclusions and Limitations" section.

Office Visits

	Copayment
Visit to Physician, Physician Assistant, Nurse Practitioner, or Podiatrist	$15
Specialist consultation	$30
Hearing examination for diagnosis or treatment	$15
Vision examination for diagnosis or treatment (ages 19 and older) by an Optometrist*	$15
Vision examination for diagnosis or treatment (ages 19 and older) by an Ophthalmologist*	$30
Physician visit to a Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$15

Specialist visit to a Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net) $30
Annual Physical Examination (1 per Calendar Year)** ....Not Covered
Telehealth consultation through the Select Telehealth Services Provider*** $0

Note(s):

- Self-referrals are allowed for obstetrician and gynecological services, and reproductive and sexual health care services. (Refer to "Obstetrician and Gynecologist (OB/GYN) Self-Referral" and "Self-Referral for Reproductive and Sexual Health Care Services" portions of the "Covered Services and Supplies" section.)
- The office visit Copayment applies to visits to your Primary Care Physician. The Specialist consultation Copayment applies to services that are performed by a Member Physician who is not your Primary Care Physician. When a Specialist is your Primary Care Physician, the office visit Copayment will apply to visits to that Physician, except as noted below for certain Preventive Care Services. See "Primary Care Physician" in the "Definitions" section for information about the types of Physicians you can choose as your Primary Care Physician.

* See "Pediatric Vision Services" for details regarding pediatric vision care services for ages younger than 19.

** For non-preventive purpose, such as taken to obtain employment or administered at the request of a third party, such as a school, camp, or sports organization. For annual preventive physical examinations, see "Preventive Care Services" below.

***The designated Select Telehealth Services Provider for this Plan is listed on your Health Net ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card.

Preventive Care Services

	Copayment
Preventive Care Services*	$0

Note(s):

- Covered Services include, but are not limited to, annual preventive physical examinations, immunizations, screening and diagnosis of prostate cancer, well-woman examinations, preventive services for pregnancy, other women's preventive services as supported by the Health Resources and Services Administration (HRSA), breastfeeding support and supplies (including one breast pump per pregnancy) and preventive vision and hearing screening examinations. Refer to the "Preventive Care Services" portion of the "Covered Services and Supplies" section for details.
- If you receive any other Covered Services in addition to Preventive Care Services during the same visit, you will also pay the applicable Copayment for those services.

* Preventive colonoscopies will be covered at no cost.

Hospital Visits by Physician

	Copayment
Physician visit to Hospital	$0

Note(s):

- The above Copayment applies to professional services only. Care that is rendered in a Hospital is also subject to the applicable facility Copayment. Look under the "Inpatient Hospital Services" heading to determine any additional Copayments that may apply.

Allergy, Immunizations and Injections

	Copayment
Allergy testing	$30
Allergy serum	10%
Allergy injection services	$15
Immunizations for occupational purposes or foreign travel	Not covered
Injections (excluding injections for infertility)	
Office based injectable medications (per dose)	10%

Note(s):

- Immunizations that are part of Preventive Care Services are covered under "Preventive Care Services" in this section.
- Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a Physician's office. If you need to have the provider administer the Specialty Drug, you will need to obtain the Specialty Drug through our contracted specialty pharmacy vendor and bring it with you to the Physician's office. Alternatively, you can coordinate delivery of the Specialty Drug directly to the provider office through our contracted specialty pharmacy vendor. Please refer to the "Tier 4 Drugs (Specialty Drugs)" portion of this "Schedule of Benefits and Copayments" section for the applicable Copayment.

Rehabilitation and Habilitation Therapy

	Copayment
Physical therapy	$15
Occupational therapy	$15
Speech therapy	$15
Pulmonary therapy	$15
Cardiac therapy	$15
Habilitative therapy	$15

Note(s):

- These services will be covered when Medically Necessary.
- Coverage for physical, occupational and speech rehabilitation and habilitation therapy services is subject to certain conditions as described under the heading "Rehabilitation and Habilitation Therapy" of the "Exclusions and Limitations" section.

Care for Conditions of Pregnancy

	Copayment
Prenatal care and preconception visits*	$0
Postnatal office visit*	$15
Newborn care office visit (birth through 30 days)*	$15
Physician visit to the mother or newborn at a Hospital**	$0
Professional Services for normal delivery, including cesarean section	$0
Normal delivery, including cesarean section	$0
Circumcision of newborn (birth through 30 days)***	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$20

Note(s):

- The above Copayments apply to the noted professional services only. Care that is rendered in a Hospital or in an outpatient surgery setting is also subject to the applicable inpatient and outpatient professional and facility Copayments. Look under the "Hospital Visits by Physician," "Other Professional Services," "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments that may apply. Genetic testing is covered as a laboratory service as shown under the "Other Professional Services" heading below. Genetic testing through the California Prenatal Screening (PNS) Program at PNS-contracted labs, and follow-up services provided through PNS-contracted labs and other PNS-contracted providers are covered in full.

* Termination of pregnancy and related services are covered in full. Prenatal, postnatal and newborn care that are Preventive Care Services are covered in full. See "Preventive Care Services" above. If other non-Preventive Care Services are received during the same office visit, the above Copayment will apply for the non-Preventive Care Services. Refer to "Preventive Care Services" and "Pregnancy" under "Covered Services and Supplies."

** One Copayment per visit.

***Circumcisions for Members age 31 days and older are covered when Medically Necessary under outpatient surgery. Refer to "Other Professional Services" and "Outpatient Facility Services" for applicable Copayments.

Family Planning

	Copayment
Sterilization of female	$0
Sterilization of male	$0

Note(s):

- Sterilization of females and contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section.

Other Professional Services

	Copayment
Surgery	
In an inpatient setting	$0
In a Physician’s office or outpatient facility	$20
Assistance at surgery	
In an inpatient setting	$0
In a Physician’s office or outpatient facility	$20
Administration of anesthetics	
In an inpatient setting	$0
In a Physician’s office or outpatient facility	$20
Chemotherapy	10%
Radiation therapy	10%
Laboratory services	$15
Diagnostic imaging (including x-ray) services	$30
CT, SPECT, MRI, MUGA and PET	$75
Medical social services	$15
Patient education*	$0
Nuclear medicine (use of radioactive materials)	10%
Renal dialysis	10%
Organ, tissue, or stem cell transplant**	See note below
Infusion therapy in a home, outpatient or office setting	10%

Note(s):

- The above Copayments apply to professional services only. Care that is rendered in a Hospital or in an outpatient surgery setting is also subject to the applicable facility Copayment. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments that may apply.
- Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry, also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.

* Covered health education counseling for diabetes, weight management and smoking cessation, including programs provided online and counseling over the phone, are covered as preventive care and have no cost sharing; however, if other medical services are provided at the same time that are not solely for the purpose of covered preventive care, the appropriate related Copayment will apply.

** Applicable Copayment requirements apply to any services and supplies required for organ, tissue, or stem cell transplants. For example, if the transplant requires an office visit, then the office visit Copayment will apply. Refer to the "Organ, Tissue and Stem Cell Transplants" portion of the "Covered Services and Supplies" section for details.

Medical Supplies

	Copayment
Durable Medical Equipment, nebulizers, including face masks and tubing*	10%
Orthotics (such as bracing, supports and casts)	10%

Diabetic equipment*	10%
Diabetic footwear	10%
Prostheses (internal or external)**	10%
Cranial prostheses (Wigs)***	10%
Blood or blood products, except for drugs used to treat hemophilia, including blood factors****	10%

Note(s):

- Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section. For additional information, please refer to the "Preventive Care Services" provision in the "Covered Services and Supplies" section.

* Corrective Footwear for the management and treatment of diabetes are covered under the "Diabetic Equipment" benefit as Medically Necessary. For a complete list of covered diabetic equipment and supplies, please see "Diabetic Equipment" in the "Covered Services and Supplies" section.

** Includes coverage of ostomy and urological supplies. See "Ostomy and Urological Supplies" portion of the "Covered Services and Supplies."

***Cranial Prostheses (wigs) following chemotherapy and/or radiation therapy services, burns or for Members who suffer from alopecia are covered and are subject to one wig per year maximum. No other coverage will be provided for wigs. Hair transplantation, hair analysis and hairpieces are not covered.

****Drugs for the treatment of hemophilia, including blood factors, are considered self-injectable drugs and covered as a Tier 4 Drug (Specialty Drug) under the Prescription Drug benefit.

Home Health Care Services

	Copayment
Home Health Care Services	$20 per visit

Limitation(s):

100 visits maximum per Calendar Year.

Hospice Services

	Copayment
Hospice care	$0

Inpatient Hospital Services

	Copayment
Room and board in a semi-private room or Special Care Unit including ancillary (additional) services	$225 per day up to 5 days

Note(s):

- The above Copayment applies to facility services only. Care that is rendered in a Hospital is also subject to the professional services Copayments. Look under the "Hospital Visits by Physician," "Care for Conditions of Pregnancy" and "Other Professional Services" headings to determine any additional Copayments that may apply.
- The above Copayment for inpatient Hospital services or Special Care Unit services is applicable for each day of the hospitalization of an adult, pediatric or newborn patient. For an inpatient stay for the delivery of a newborn, the newborn will not be subject to a separate Copayment for inpatient Hospital services unless the newborn patient requires admission to a Special Care Unit or requires a length of stay greater than 48 hours for vaginal delivery or 96 hours for caesarean section.
- No additional Copayment after the first 5 days of a continuous inpatient Hospital stay.

Outpatient Facility Services

	Copayment
Outpatient surgery facility (surgery performed in a Hospital outpatient setting or Outpatient Surgical Center)	$75
Outpatient facility services (other than surgery)	10%

Note(s):

- The above Copayments apply to facility services only. Care that is rendered in an outpatient surgery setting is also subject to the professional services Copayments. Look under the "Care for Conditions of Pregnancy" and "Other Professional Services" headings to determine any additional Copayments that may apply.
- Other professional services performed in the outpatient department of a Hospital, such as a visit to a Physician (office visit), laboratory and x-ray services, physical therapy, etc. are subject to the same Copayment which is required when these services are performed at your Physician's office. Look under the headings for the various services such as office visits, neuromuscular rehabilitation and other professional services to determine any additional Copayments that may apply.
- Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the "Preventive Care Services" section above.
- Use of a Hospital emergency room appears in the first item at the beginning of this section.

Skilled Nursing Facility Services

	Copayment
Room and board in a semi-private room with ancillary (additional) services	$125 per day up to 5 days

Note(s):

- No additional Copayment after the first 5 days of a continuous Skilled Nursing Facility stay.

- Skilled Nursing Facility services are covered for up to a maximum of 100 days per Calendar Year for each Member.

Mental Health and Substance Use Disorders

	Copayment
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring)	$15
Outpatient group therapy session	$7.50
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, outpatient detoxification, intensive outpatient care program, day treatment and partial hospitalization)	$0
Participating Mental Health Professional visit to a Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Health Net)	$15
Participating Mental Health Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	$0
Inpatient services at a Hospital, Behavioral Health Facility or Residential Treatment Center	$225 per day up to 5 days
Detoxification	$225 per day up to 5 days

Note(s):

- Each group therapy session counts as one half of a private office visit for each Member participating in the session.
- The applicable Copayment for outpatient services is required for each visit.

Exception(s):

- If two or more Members in the same family attend the same outpatient treatment session, only one Copayment will be applied.

Prescription Drugs

Refer to the **Note** below for clarification of your financial responsibility regarding Copayment.

	Copayment
Retail Pharmacy (up to a 30 day supply)	
Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs	$7
Tier 2 Drugs include non-preferred Generic Drugs, preferred Brand Name Drugs and any other drugs recommended by the Health Net Pharmacy and Therapeutics Committee based on safety, efficacy, and cost	$16
Tier 3 Drugs include non-preferred Brand Name Drugs or drugs that are recommended by the Health Net Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier	$25

Preventive drugs and contraceptives..$0

Tier 4 Drugs (Specialty Drugs) (up to a 30 day supply)

Tier 4 Drugs (Specialty Drugs) are drugs that are biologics, drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost Health Net more than six hundred dollars for a one-month supply. .... 10% up to $250 per script

Maintenance Drugs through the Mail Order Program (up to a 90 day supply)

Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs $14
Tier 2 Drugs include non-preferred Generic Drugs, preferred Brand Name Drugs and any other drugs recommended by the Health Net Pharmacy and Therapeutics Committee based on safety, efficacy, and cost...$32
Tier 3 Drugs include non-preferred Brand Name Drugs or drugs that are recommended by the Health Net Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier...$50
Preventive drugs and contraceptives..$0

Note(s):

- **Orally administered anti-cancer drugs will have a Copayment maximum of $250 for an individual prescription of up to a 30-day supply.**
- To obtain specific benefit and drug information, including your cost for a specific drug at your preferred pharmacy, please log into your secure member portal or call the Customer Contact Center at the number on your Health Net ID card.
- "Split-fill" Program: For certain high cost orally administered anti-cancer drugs, Health Net provides a free 14-day trial. Drugs under the Split-fill program are indicated in the Essential Rx Drug List with "SF" in the comment section. Health Net will approve the initial fill for a 14-day supply at no cost to you. If, after the initial fill, you are free of adverse effects and wish to continue on the drug, the subsequent fills will be dispensed for the full quantity as written by your Physician. You will be charged the applicable Copayment for each subsequent fill, up to the Copayment maximum for orally administered anti-cancer drugs described above.
- For information about Health Net's Essential Rx Drug List, please call the Customer Contact Center at the telephone number on your ID card.
- You will be charged a Copayment for each Prescription Drug Order.
- Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed. For a complete description of Prescription Drug benefits, exclusions and limitations, please refer to the "Prescription Drugs" portion of the "Covered Services and Supplies" and the "Exclusions and Limitations" sections.
- Percentage Copayments will be based on Health Net's contracted pharmacy rate.

- Regardless of prescription drug tier, Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover Brand Name Drugs, including Specialty Drugs, that have generic equivalents only when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net. Covered Brand Name Drugs are subject to the applicable Copayment for Tier 2, Tier 3 or Tier 4 (Specialty Drugs) Prescription Drugs.

Prior Authorization:

Prior Authorization may be required. Refer to the "Prescription Drugs" portion of the "Covered Services and Supplies" section for a description of Prior Authorization requirements or visit our website at www.myhealthnetca.com to obtain a list of drugs that require Prior Authorization.

Copayment Exception(s):

If the pharmacy's or the mail order administrator's retail price is less than the applicable Copayment, the Member will only pay the pharmacy's retail price or the mail order administrator's retail price.

Preventive Drugs and Contraceptives:

Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration and recommended by the United States Preventive Services Task Force (USPSTF) are covered at no cost to the Member. Covered preventive drugs include over-the-counter drugs and Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Forces A and B recommendations, including smoking cessation drugs. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order. Please see the "Preventive Drugs and Contraceptives" provision in the "Prescription Drugs" portion of the "Covered Services and Supplies" section for additional details.

Generic Drugs will be dispensed when a Generic Drug equivalent is available. However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the Brand Name Drug will be dispensed at no charge.

Mail Order:

Up to a 90 consecutive-calendar-day supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment. However, when the retail Copayment is a percentage, the mail order Copayment is the same percentage of the cost to Health Net as the retail Copayment.

Diabetic Supplies:

Diabetic supplies (blood glucose testing strips, lancets, disposable needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e., opened in order to dispense the product in quantities other than as packaged).

When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your Physician has prescribed for up to a 30-day period.

Tier 4 (Specialty Drugs)

Tier 4 (Specialty Drugs) are specific Prescription Drugs that may have limited pharmacy availability or distribution, may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously) requiring the Member to have special training or clinical monitoring for self-administration, includes biologics and drugs that the FDA or drug manufacturer requires to be distributed through a specialty pharmacy, or have high cost as established by Covered California. Tier 4 Drugs (Specialty Drugs) are identified in the Essential Rx Drug List with "SP," require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered. Tier 4 Drugs (Specialty Drugs) are not available through mail order.

Pediatric Dental Services

Except as otherwise provided in the "Pediatric Dental Services" portion of "Covered Services and Supplies," and "Pediatric Dental Services" portion of "Introduction to Health Net," all of the following services must be provided by your selected Health Net Participating Primary Dental Provider in order to be covered. Refer to the "Pediatric Dental Services" portion of "Exclusions and Limitations" for limitations on covered pediatric dental services.

Pediatric dental services are covered until the last day of the month in which the individual turns nineteen years of age.

If you have purchased a supplemental pediatric dental benefit plan, pediatric dental benefits covered under this Plan will be paid first, with the supplemental pediatric dental benefit plan covering non-covered services and or cost sharing as described in your supplemental pediatric dental benefit plan coverage document.

IMPORTANT: If you opt to receive dental services that are not Covered Services under this Plan, a participating dental provider may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not covered benefits, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call the Customer Contact Center at the telephone number on your Health Net dental ID card or your insurance broker. To fully understand your coverage, you may wish to carefully review this *Plan Contract and Evidence of Coverage* document.

Administration of these pediatric dental plan designs comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for pediatric dental services.

Code	Service	Member Copayment
Diagnostic		
D0120	Periodic oral evaluation - established patient limited to 1 every 6 months	No Charge
D0140	Limited oral evaluation - problem focused	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	Comprehensive oral evaluation - new or established patient	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit) up to six times in a 3 month period and up to a maximum of 12 in a 12 month period	No Charge
D0171	Re-evaluation - post-operative office visit	No Charge

Code	Service	Member Copayment
D0180	Comprehensive periodontal evaluation - new or established patient	No Charge
D0210	X-rays Intraoral - comprehensive series (including bitewings) limited to once per provider every 36 months	No Charge
D0220	X-rays Intraoral - periapical first film limited to a maximum of 20 periapicals in a 12 month period by the same provider, in any combination of the following: intraoral-periapical first radiographic image (D0220) and intraoral-periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12 month period	No Charge
D0230	X-rays Intraoral - periapical each additional film limited to a maximum of 20 periapicals in a 12 month period	No Charge
D0240	X-rays Intraoral - occlusal film limited to 2 in a 6 month period	No Charge
D0250	Extraoral, 2D projection radiographic image created using a stationary radiation source, and detector - first film	No Charge
D0251	Extraoral posterior dental radiographic image	No Charge
D0270	X-rays Bitewing - single film limited to once per date of service	No Charge
D0272	X-rays Bitewings - two films limited to once every 6 months	No Charge
D0273	X-rays Bitewings - three films	No Charge
D0274	X-rays Bitewings - four films - limited to once every 6 months	No Charge
D0277	Vertical bitewings - 7 to 8 films	No Charge
D0310	Sialography	No Charge
D0320	Temporomandibular joint arthrogram, including injection limited to a maximum of 3 per date of service	No Charge
D0322	Tomographic survey limited to twice in a 12 month period	No Charge
D0330	Panoramic film limited to once in a 36 month period per provider, except when documented as essential for a follow-up/post-operative exam (such as after oral surgery)	No Charge
D0340	2D Cephalometric radiographic image limited to twice in a 12 month period per provider	No Charge

Code	Service	Member Copayment
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally 1st limited to a maximum of 4 per date of service	No Charge
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts may be provided only if one of the above conditions is present	No Charge
D0502	Other oral pathology procedures, by report	No Charge
D0601	Caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	Caries risk assessment and documentation, with a finding of high risk	No Charge
D0701	Panoramic radiographic image - image capture only	No Charge
D0702	2-D cephalometric radiographic image - image capture only	No Charge
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Charge
D0705	Extra-oral posterior dental radiographic image - image capture only	No Charge
D0706	Intraoral - occlusal radiographic image - image capture only	No Charge
D0707	Intraoral - periapical radiographic image - image capture only	No Charge
D0708	Intraoral - bitewing radiographic image - image capture only	No Charge
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Charge
D0801	3D dental surface scan - direct	No Charge
D0802	3D dental surface scan - indirect	No Charge
D0803	3D facial surface scan - direct	No Charge
D0804	3D facial surface scan - indirect	No Charge
D0999	Office visit fee - per visit (Unspecified diagnostic procedure, by report)	No Charge
Preventive		

Code	Service	Member Copayment
D1110	Prophylaxis - adult limited to once in a 12 month period	No Charge
D1120	Prophylaxis - child limited to once in a 6 month period	No Charge
D1206	Topical fluoride varnish limited to once in a 6 month period	No Charge
D1208	Topical application of fluoride excluding varnish limited to once in a 6 month period	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth limited to first, second and third permanent molars that occupy the second molar position	No Charge
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth limited to first, second and third permanent molars that occupy the second molar position	No Charge
D1353	Sealant repair - per tooth	No Charge
D1354	Interim caries arresting medicament application - per tooth	No Charge
D1355	Caries preventive medicament application - per tooth	No Charge
D1510	Space maintainer - fixed - unilateral limited to once per quadrant	No Charge
D1516	Space maintainer - fixed - bilateral, maxillary	No Charge
D1517	Space maintainer - fixed - bilateral, mandibular	No Charge
D1520	Space maintainer - removable - unilateral limited to once per quadrant	No Charge
D1526	Space maintainer - removable - bilateral, maxillary	No Charge
D1527	Space maintainer - removable - bilateral, mandibular	No Charge
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Charge
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Charge

Code	Service	Member Copayment
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Charge
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Charge
D1557	Removal of fixed bilateral space maintainer - maxillary	No Charge
D1558	Removal of fixed bilateral space maintainer - mandibular	No Charge
D1575	Distal shoe space maintainer - fixed - unilateral - per quadrant	No Charge
Restorative		
D2140	Amalgam - one surface, primary limited to once in a 12 month period	$25
D2140	Amalgam - one surface, permanent limited to once in a 36 month period	$25
D2150	Amalgam - two surfaces, primary limited to once in a 12 month period	$30
D2150	Amalgam - two surfaces, permanent limited to once in a 36 month period	$30
D2160	Amalgam - three surfaces, primary limited to once in a 12 month period	$40
D2160	Amalgam - three surfaces, permanent limited to once in a 36 month period	$40
D2161	Amalgam - four or more surfaces, primary limited to once in a 12 month period	$45
D2161	Amalgam - four or more surfaces, permanent limited to once in a 36 month period	$45
D2330	Resin-based composite - one surface, anterior, primary limited to once in a 12 month period	$30
D2330	Resin-based composite - one surface, anterior, permanent limited to once in a 36 month period	$30
D2331	Resin-based composite - two surfaces, anterior primary limited to once in a 12 month period	$45
D2331	Resin-based composite - two surfaces, anterior permanent limited to once in a 36 month period	$45
D2332	Resin-based composite - three surfaces, anterior primary limited to once in a 12 month period	$55

Code	Service	Member Copayment
D2332	Resin-based composite - three surfaces, anterior permanent limited to once in a 36 month period	$55
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) primary limited to once in a 12 month period	$60
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) permanent limited to once in a 36 month period	$60
D2390	Resin-based composite crown, anterior, primary limited to once in a 12 month period	$50
D2390	Resin-based composite crown, anterior, permanent limited to once in a 36 month period	$50
D2391	Resin-based composite - one surface, posterior primary limited to once in a 12 month period	$30
D2391	Resin-based composite - one surface, posterior permanent limited to once in a 36 month period	$30
D2392	Resin-based composite - two surfaces, posterior; primary limited to once in a 12 month period	$40
D2392	Resin-based composite - two surfaces, posterior; permanent limited to once in a 36 month period	$40
D2393	Resin-based composite - three surfaces, posterior; primary limited to once in a 12 month period	$50
D2393	Resin-based composite - three surfaces, posterior; permanent limited to once in a 36 month period	$50
D2394	Resin-based composite - four or more surfaces, posterior; primary limited to once in a 12 month period	$70
D2394	Resin-based composite - four or more surfaces, posterior; permanent limited to once in a 36 month period	$70
D2710	Crown - Resin-based composite (indirect) limited to once in a 5 year period	$140
D2712	Crown - ¾ resin-based composite (indirect) limited to once in a 5 year period	$190
D2721	Crown - Resin with predominantly base metal limited to once in a 5 year period	$300
D2740	Crown - porcelain/ceramic limited to once in a 5 year period	$300

Code	Service	Member Copayment
D2751	Crown - porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D2781	Crown - ¾ cast predominantly base metal limited to once in a 5 year period	$300
D2783	Crown - ¾ porcelain/ceramic limited to once in a 5 year period	$310
D2791	Crown - full cast predominantly base metal limited to once in a 5 year period	$300
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration limited to once in a 12 month period	$25
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	$25
D2920	Recement or re-bond crown	$25
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$120
D2929	Prefabricated porcelain/ceramic crown - primary tooth limited to once in a 12 month period	$95
D2930	Prefabricated stainless steel crown - primary tooth limited to once in a 12 month period	$65
D2931	Prefabricated stainless steel crown - permanent tooth limited to once in a 36 month period	$75
D2932	Prefabricated Resin Crown, primary limited to once in a 12 month period	$75
D2932	Prefabricated Resin Crown, permanent limited to once in a 36 month period	$75
D2933	Prefabricated Stainless steel crown with resin window, primary limited to one in a 12 month period	$80
D2933	Prefabricated Stainless steel crown with resin window, permanent limited to once in a 36 month period	$80
D2940	Protective restoration limited to once per tooth in a 12 month period	$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
D2951	Pin retention - per tooth, in addition to restoration	$25

Code	Service	Member Copayment
D2952	Post and core in addition to crown, indirectly fabricated limited to once per tooth regardless of number of posts placed	$100
D2953	Each additional indirectly fabricated post - same tooth	$30
D2954	Prefabricated post and core in addition to crown limited to once per tooth regardless of number of posts placed	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post - same tooth	$35
D2971	Additional procedures to customize a crown to fit under an existing partial dental framework	$35
D2980	Crown repair necessitated by restorative material failure, by report. Limited to laboratory processed crowns on permanent teeth. Not a benefit within 12 months of initial crown placement or previous repair for the same provider.	$50
D2999	Unspecified restorative procedure, by report	$40
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 limited to once per primary tooth	$40
D3221	Pupal debridement primary and permanent teeth	$40
D3222	Partial Pulpotomy for apexogenesis, permanent tooth with incomplete root development limited to once per permanent tooth	$60
D3230	Pulpal therapy (resorbable filing) - anterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55
D3240	Pulpal therapy (resorbable filing) - posterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55
D3310	Endodontic (Root canal) therapy, Anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$195

Code	Service	Member Copayment
D3320	Endodontic (Root canal) therapy, premolar (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$235
D3330	Endodontic (Root canal) therapy, Molar tooth (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50
D3333	Internal root repair of perforation defects	$80
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	$350
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) limited to once per permanent tooth	$85
D3352	Apexification/recalcification - interim medication replacement only following D3351. Limited to once per permanent tooth	$45
D3410	Apicoectomy - anterior	$240
D3421	Apicoectomy - premolar (first root)	$250
D3425	Apicoectomy - molar (first root)	$275
D3426	Apicoectomy (each additional root)	$110
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$350
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$350
D3430	Retrograde filling - per root	$90
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery	$80
D3471	Surgical repair of root resorption - anterior	$160
D3472	Surgical repair of root resorption - premolar	$160
D3473	Surgical repair of root resorption - molar	$160
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3999	Unspecified endodontic procedure, by report	$100
Periodontics		

Code	Service	Member Copayment
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	$150
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	$50
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 spaces per quadrant - once per quadrant every 36 months	$265
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$80
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - once per quadrant every 24 months	$55
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - once per quadrant every 24 months	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$40
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10
D4910	Periodontal maintenance limited to once in a calendar quarter	$30
D4920	Unscheduled dressing change (by someone other than treating dentist). Once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).	$15
D4999	Unspecified periodontal procedure, by report	$350
Prosthodontics, removable		

Code	Service	Member Copayment
D5110	Complete denture - maxillary limited to once in a 5 year period from a previous complete, immediate or overdenture- complete denture	$300
D5120	Complete denture - mandibular limited to once in a 5 year period from a previous complete, immediate or overdenture- complete denture	$300
D5130	Immediate denture - maxillary	$300
D5140	Immediate denture - mandibular	$300
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	$300
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	$335
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	$335
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330
D5410	Adjust complete denture - maxillary limited to once per date of service; twice in a 12 month period	$20
D5411	Adjust complete denture - mandibular limited to once per date of service; twice in a 12 month period	$20
D5421	Adjust partial denture - maxillary limited to once per date of service; twice in a 12 month period	$20

Code	Service	Member Copayment
D5422	Adjust partial denture - mandibular limited to once per date of service; twice in a 12 month period	$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) limited to a maximum of four, per arch, per date of service; twice per arch in a 12 month period	$40
D5611	Repair resin denture base, mandibular	$40
D5612	Repair resin denture base, maxillary	$40
D5621	Repair cast framework, mandibular	$40
D5622	Repair cast framework, maxillary	$40
D5630	Repair or replace broken retentive/clasping materials- per tooth - limited to a maximum of three, per date of service; twice per arch in a 12 month period	$50
D5640	Replace broken teeth - per tooth - limited to maximum of four, per arch, per date of service; twice per arch in a 12 month period	$35
D5650	Add tooth to existing partial denture limited to a maximum of three, per date of service; once per tooth	$35
D5660	Add clasp to existing partial denture - per tooth - limited to a maximum of three, per date of service; twice per arch in a 12 month period	$60
D5730	Reline complete maxillary denture (chairside) limited to once in a 12 month period	$60
D5731	Reline complete mandibular denture (chairside) limited to once in a 12 month period	$60
D5740	Reline maxillary partial denture (chairside) limited to once in a 12 month period	$60
D5741	Reline mandibular partial denture (chairside) limited to once in a 12 month period	$60
D5750	Reline complete maxillary denture (laboratory) limited to once in a 12 month period	$90
D5751	Reline complete mandibular denture (laboratory) limited to once in a 12 month period	$90
D5760	Reline maxillary partial denture (laboratory) limited to once in a 12 month period	$80

Code	Service	Member Copayment
D5761	Reline mandibular partial denture (laboratory) limited to once in a 12 month period	$80
D5850	Tissue conditioning, maxillary limited to twice per prosthesis in a 36 month period	$30
D5851	Tissue conditioning, mandibular maxillary limited to twice per prosthesis in a 36 month period. Not a benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions.	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture - complete maxillary	$300
D5864	Overdenture - partial maxillary	$300
D5865	Overdenture - complete mandibular	$300
D5866	Overdenture - partial mandibular	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
Maxillofacial Prosthetics		
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

Code	Service	Member Copayment
D5929	Facial prosthesis, replacement	$200
D5931	Obturator prosthesis, surgical	$350
D5932	Obturator prosthesis, definitive	$350
D5933	Obturator prosthesis, modification limited to twice in a 12 month period	$150
D5934	Mandibular resection prosthesis with guide flange	$350
D5935	Mandibular resection prosthesis without guide flange	$350
D5936	Obturator prosthesis, interim	$350
D5937	Trismus appliance (not for TMD treatment)	$85
D5951	Feeding aid	$135
D5952	Speech aid prosthesis, pediatric	$350
D5953	Speech aid prosthesis, adult	$350
D5954	Palatal augmentation prosthesis	$135
D5955	Palatal lift prosthesis, definitive	$350
D5958	Palatal lift prosthesis, interim	$350
D5959	Palatal lift prosthesis, modification limited to twice in a 12 month period	$145
D5960	Speech aid prosthesis, modification limited to twice in a 12 month period	$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
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	$350

Code	Service	Member Copayment
D6011	Surgical access to an implant body (second stage implant surgery)	$350
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant	$350
D6013	Surgical placement of mini-implant	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$350
D6055	Connecting bar - implant supported or abutment supported	$350
D6056	Prefabricated abutment - includes modification and placement	$135
D6057	Custom fabricated abutment - includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315
D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported crown (porcelain fused to high noble alloys)	$335
D6067	Implant supported crown (high noble alloys)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300

Code	Service	Member Copayment
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335
D6076	Implant supported retainer for FPD (porcelain fused to high noble alloys)	$330
D6077	Implant supported retainer for metal FPD (high noble alloys)	$350
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30
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
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335
D6083	Implant supported crown - porcelain fused to noble alloys	$335
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335
D6085	Interim implant crown	$300
D6086	Implant supported crown - predominantly base alloys	$340
D6087	Implant supported crown - noble alloys	$340
D6088	Implant supported crown - titanium and titanium alloys	$340
D6090	Repair implant supported prosthesis, by report	$65
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown - titanium and titanium alloys	$295
D6095	Repair implant abutment, by report	$65

Code	Service	Member Copayment
D6096	Removal of broken implant retaining screw	$60
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330
D6100	Surgical removal of implant body	$110
D6105	Removal of implant body not requiring bone removal or flap elevation	$110
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	$350
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary	$350
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350
D6122	Implant supported retainer for metal FPD - noble alloys	$350

Code	Service	Member Copayment
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350
D6190	Radiographic/Surgical implant index, by report	$75
D6191	Semi-precision abutment - placement	$350
D6192	Semi-precision attachment - placement	$350
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$265
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$95
D6198	Remove interim implant component	$110
D6199	Unspecified implant procedure, by report	$350
Prosthodontics, fixed		
D6211	Pontic - cast predominantly base metal limited to once in a 5 year period	$300
D6241	Pontic - porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D6245	Pontic - porcelain/ceramic limited to once in a 5 year period	$300
D6251	Pontic - resin with predominantly base metal limited to once in a 5 year period	$300
D6721	Retainer Crown - resin predominantly base metal - denture limited to once in a 5 year period	$300
D6740	Retainer Crown - porcelain/ceramic limited to once in a 5 year period	$300
D6751	Retainer Crown - porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D6781	Retainer Crown - ¾ cast predominantly base metal limited to once in a 5 year period	$300
D6783	Retainer Crown - ¾ porcelain/ceramic limited to once in a 5 year period	$300
D6784	Retainer Crown - ¾ titanium and titanium alloys	$300

Code	Service	Member Copayment
D6791	Retainer Crown - full cast predominantly base metal limited to once in a 5 year period	$300
D6930	Recement 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
Oral Maxillofacial Prosthetics		
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, including elevation of mucoperiosteal flap if indicated	$120
D7220	Removal of impacted tooth - soft tissue	$95
D7230	Removal of impacted tooth - partially bony	$145
D7240	Removal of impacted tooth - completely bony	$160
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175
D7250	Removal of residual tooth roots (cutting procedure)	$80
D7260	Oroantral fistula closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth - limited to once per arch regardless of the number of teeth involved; permanent anterior teeth only	$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) limited to removal of the specimen only; once per arch per date of service	$180
D7286	Incisional biopsy of oral tissue - soft limited to removal of the specimen only; up to a maximum of 3 per date of service	$110

Code	Service	Member Copayment
D7290	Surgical repositioning of teeth; permanent teeth only; once per arch for patients in active orthodontic treatment	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment	$80
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. A benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.	$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) limited to once in a 5 year period per arch	$350
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) limited to once per arch	$350
D7410	Excision of benign lesion up 1.25 cm	$75
D7411	Excision of benign lesion greater than 1.25 cm	$115
D7412	Excision of benign lesion, complicated	$175
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

Code	Service	Member Copayment
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
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40
D7471	Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial exostosis only	$140
D7472	Removal of torus palatinus limited to once in a patient’s lifetime	$145
D7473	Removal of torus mandibularis limited to once per quadrant	$140
D7485	Surgical reduction of osseous tuberosity limited to once per quadrant	$105
D7490	Radical resection of maxilla or mandible	$350
D7509	Marsupialization of odontogenic cyst	$180
D7510	Incision and drainage of abscess - intraoral soft tissue limited to once per quadrant, same date of service	$70
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) limited to once per quadrant, same date of service	$70
D7520	Incision and drainage of abscess - extraoral soft tissue	$70
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of service	$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of service	$75
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone limited to once per quadrant per date of service	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235

Code	Service	Member Copayment
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250
D7630	Mandible - open reduction (teeth immobilized, if present)	$350
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch - open reduction	$350
D7660	Malar and/or zygomatic arch - closed reduction	$350
D7670	Alveolus - closed reduction, may include stabilization of teeth	$170
D7671	Alveolus - open reduction, may include stabilization of teeth	$230
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla - open reduction	$110
D7720	Maxilla - closed reduction	$180
D7730	Mandible - open reduction	$350
D7740	Mandible - closed reduction	$290
D7750	Malar and/or zygomatic arch - open reduction	$220
D7760	Malar and/or zygomatic arch - closed reduction	$350
D7770	Alveolus - open reduction stabilization of teeth	$135
D7771	Alveolus, closed reduction stabilization of teeth	$160
D7780	Facial bones - complicated reduction with fixation and multiple 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

Code	Service	Member Copayment
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90
D7871	Non-arthroscopic lysis and lavage	$150
D7872	Arthroscopy - diagnosis, with or without biopsy	$350
D7873	Arthroscopy - lavage and lysis of adhesions	$350
D7874	Arthroscopy - disc repositioning and stabilization	$350
D7875	Arthroscopy - synovectomy	$350
D7876	Arthroscopy - discectomy	$350
D7877	Arthroscopy - 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
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80
D7940	Osteoplasty - for orthognathic deformities	$160
D7941	Osteotomy - mandibular rami	$350
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy - segmented or subapical	$275
D7945	Osteotomy - body of mandible	$350
D7946	LeFort I (maxilla - total)	$350
D7947	LeFort I (maxilla - segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350
D7949	LeFort II or LeFort III - with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla - autogenous or nonautogenous, by report	$190

Code	Service	Member Copayment
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
D7961	Buccal/labial frenectomy (frenulectomy)	$120
D7962	Lingual frenectomy (frenulectomy)	$120
D7963	Frenuloplasty limited to once per arch per date of service	$120
D7970	Excision of hyperplastic tissue - per arch limited to once per arch per date of service	$175
D7971	Excision of pericoronal gingiva	$80
D7972	Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service	$100
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 limited to once per arch per date of service	$60
D7999	Unspecified oral surgery procedure, by report	$350
Orthodontics	Medically Necessary banded case (The Copayment applies to a Member’s course of treatment as long as that Member remains enrolled in this Plan)	$1000
D8080	Comprehensive orthodontic treatment of the adolescent dentition handicapping malocclusion	
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment examination to monitor growth and development	

Code	Service	Member Copayment
D8670	Periodic orthodontic treatment visit	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8681	Removable orthodontic retainer adjustment	
D8696	Repair of orthodontic appliance - maxillary	
D8697	Repair of orthodontic appliance - mandibular	
D8698	Recement or re-bond fixed retainer - maxillary	
D8699	Recement or re-bond fixed retainer - mandibular	
D8701	Repair of fixed retainer, includes reattachment - maxillary	
D8702	Repair of fixed retainer, includes reattachment - mandibular	
D8703	Replacement of lost or broken retainer - maxillary	
D8704	Replacement of lost or broken retainer - mandibular	
D8999	Unspecified orthodontic procedure, by report	
Adjunctive General Services		
D9110	Palliative treatment of dental Pain - per visit	$30
D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service	$10
D9211	Regional block anesthesia	$20
D9212	Trigeminal division block anesthesia	$60
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$45
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/analgesia, anxiolysis	$15
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$60

Code	Service	Member Copayment
D9243	Intravenous moderate (conscious) sedation/analgesia - 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 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 limited to once per date of service only with treatment that is a benefit	$45
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament limited to once in a 12 month period; permanent teeth only	$20
D9930	Treatment of complications - post surgery, unusual circumstances, by report limited to once per date of service	$35
D9950	Occlusion analysis - mounted case limited to once in a 12 month period	$120
D9951	Occlusal adjustment - limited. Limited to once in a 12 month period per quadrant	$45
D9952	Occlusal adjustment - complete. Limited to once in a 12 month period following occlusion analysis- mounted case (D9950)	$210
D9995	Teledentistry - synchronous; real-time encounter. Limited to twice in a 12 month period	No Charge
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review. Limited to twice in a 12 month period	No Charge
D9997	Dental case management - patients with special health care needs	$0
D9999	Unspecified adjunctive procedure, by report	$0

Dental codes from "Current Dental Terminology© American Dental Association."

Pediatric Vision Services

All of the following services must be provided by a Health Net Participating Vision Provider in order to be covered. Refer to the "Pediatric Vision Services" portion of "Exclusions and Limitations" for limitation on covered pediatric vision services.

The pediatric vision services benefits are provided by Health Net. Health Net contracts with Envolve Vision, Inc., a vision services provider panel, to administer the pediatric vision services benefits.

Pediatric vision services are covered until the last day of the month in which the individual turns nineteen years of age.

Professional Services

	Copayment
Routine eye examination with dilation	$0*
Examination for contact lenses	
Standard contact lens fit and follow-up	$0*
Premium contact lens fit and follow-up	$0*

Limitation(s):

* In accordance with professionally recognized standards of practice, this Plan covers one complete vision examination once every Calendar Year.

Note(s):

- Examination for contact lenses is in addition to the Member's vision examination. There is no additional Copayment for contact lens follow-up visit after the initial fitting exam.
- **Benefits may not be combined with any discounts, promotional offerings or other group benefit plans. Allowances are one time use benefits. No remaining balance.**
- Standard contact lens includes soft, spherical and daily wear contact lenses.
- Premium contact lens includes toric, bifocal, multifocal, cosmetic color, post-surgical and gas permeable contact lenses.

Materials (includes frames and lenses)

	Copayment
Provider selected Frames (one every 12 months)	$0
Standard Eyeglass Lenses (one pair every 12 months)	$0

- Single vision, bifocal, trifocal, lenticular
- Glass or plastic, including polycarbonate

Optional Lenses and Treatments including: $0

- UV treatment
- Tint (fashion & gradient & glass-grey)
- Standard plastic scratch coating
- Photochromatic/transitions plastic

- Standard anti-reflective coating
- Polarized
- Standard progressive lenses
- Hi-index lenses
- Blended segment lenses
- Intermediate vision lenses
- Select or ultra-progressive lenses

Premium Progressive Lenses $0

Provider selected contact lenses are covered, based upon the type of contact lenses selected, every Calendar Year (in lieu of eyeglass lenses) $0

- Standard (hard) contacts 1 contact per eye per every 12 months
- Monthly contacts (six-month supply) 6 lenses per eye
- Bi-weekly (three-month supply) 6 lenses per eye
- Dailies (one-month supply) 30 lenses per eye (60 lenses)
- Medically Necessary*

* Contact lenses may be Medically Necessary for the treatment of conditions, including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

Medically Necessary Contact Lenses:

Coverage of Medically Necessary contact lenses is subject to Medical Necessity and all applicable exclusions and limitations. See "Pediatric Vision Services" portion of the "Exclusions and Limitations" for details of limitations.

Acupuncture Services

Acupuncture Services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage. With this program, you may obtain care by selecting a Contracted Acupuncturist from the *ASH Plans Contracted Acupuncturist Directory*.

Office Visits

	Copayment
New patient examination	$15
Each subsequent visit	$15
Re-examination visit	$15
Second opinion	$15

Note(s):

- If the re-evaluation occurs during a subsequent visit, only one Copayment will be required.

Limitation(s):

- Acupuncture Services, typically provided only for the treatment of Nausea or as part of a comprehensive Pain management program for the treatment of chronic Pain, are covered when Medically Necessary.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum (OOPM) amounts below are the maximum amounts you must pay for Covered Services during a particular Calendar Year, except as described in "Exceptions to OOPM" below.

Once the total amount of all Copayments you pay for Covered Services and supplies under this *Plan Contract* in any one Calendar Year equals the Out-of-Pocket Maximum amount, no payment for Covered Services and supplies may be imposed on any Member, except as described in "Exceptions to OOPM" below.

The OOPM amounts for this Plan are:

One Member $4,500
Family $9,000

Exceptions to OOPM

Your payments for services or supplies that this Plan does not cover will not be applied to the OOPM amount.

The following Copayments and expenses paid by you for Covered Services or supplies under this Plan will not be applied to the OOPM amount:

- Copayments for Health Net Individual and Family Plus Plan Vision Services benefits and expenses incurred in excess of covered Eyewear.
- Copayments for Health Net Individual and Family Plus Plan Dental Services benefits

You are required to continue to pay charges for the exceptions listed above after the OOPM has been reached.

How the OOPM Works

Here's how the OOPM works:

- If an individual Member pays amounts for Covered Services and supplies in a Calendar Year that equal the OOPM amount shown above for an individual Member, no further payment is required for that Member for the remainder of the Calendar Year.
- Once an individual Member in a family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay the Copayments until either (a) the aggregate of such Copayments paid by the family reaches the family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.
- If amounts for Covered Services and supplies paid for all enrolled Members equal the OOPM amount shown for a family, no further payment is required from any enrolled Member of that family for the remainder of the Calendar Year for those services. (Note: In order for the Family Out-of-Pocket Maximum to apply, all Family Members must be enrolled under a single Subscriber. Family Members enrolled as separate Subscribers are each subject to the One Member Out-of-Pocket Maximum.)

- Only amounts that are applied to the individual Member's OOPM amount may be applied to the family's OOPM amount. Any amount you pay for Covered Services for yourself that would otherwise apply to your individual OOPM but exceeds the above stated OOPM amount for one Member will be refunded to you by Health Net and will not apply toward your family's OOPM. Individual Members cannot contribute more than their individual OOPM amount to the family OOPM.

You will be notified by us of your OOPM accumulation for each month in which benefits were used. You will also be notified by us when you have reached your OOPM amount for the Calendar Year. You can also obtain an update on your OOPM accumulation by calling the Customer Contact Center at the telephone number on your ID card. Please keep a copy of all receipts and canceled checks for costs for Covered Services and supplies as proof of payments made.